



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR 18 2003

TO: Thomas Scully
Administrator
Centers for Medicare and Medicaid Services

FROM: Dennis J. Duquette *DJ Duquette*
Acting Principal Deputy Inspector General

SUBJECT: Review of Medicaid Disproportionate Share Hospital Payments Made by Virginia's Department of Medical Assistance Services to the Medical College of Virginia Hospitals for the Fiscal Years Ending June 30, 1997 and June 30, 1998 (A-03-01-00222)

This memorandum is to alert you to the issuance of the subject audit report within 5 business days from the date of this memorandum. A copy of the report is attached. The review was conducted at the request of the Centers for Medicare and Medicaid Services (CMS) as part of a multi-state initiative focusing on Medicaid disproportionate share hospital (DSH) payments made under section 1923 of the Social Security Act (the Act).

The objectives of our review were to determine if DSH payments made by Virginia's Department of Medical Assistance Services (DMAS) to the Medical College of Virginia Hospitals (MCVH) for state fiscal years (SFY) 1997 and 1998: (1) were calculated in accordance with the approved Medicaid state plan (state plan) and (2) did not exceed the hospital's uncompensated care cost (UCC) as imposed by the Omnibus Budget Reconciliation Act of 1993.

Our audit found that DMAS made \$117 million in DSH payments to MCVH for SFY 1997 and \$80 million for SFY 1998. The DSH payments were calculated in accordance with the state plan. The MCVH calculated UCC of \$117 million and \$104 million for SFYs 1997 and 1998.

We believe MCVH overstated its UCC by including costs that were not consistent with the apparent purpose of section 1923 of the Act. We identified unallowable costs included in UCC totaling over \$12 million for both SFYs 1997 and 1998. Unallowable costs consisted of physician practice plan costs incurred by a related entity. As a result, DSH payments for SFY 1997 exceeded UCC by \$12.2 million (\$6.3 million federal share). For SFY 1998, DSH payments did not exceed UCC.

We also were unable to determine the reasonableness of UCC totaling more than \$91 million for SFY 1997 and \$83 million for SFY 1998 because we do not believe that MCVH's methodology used to calculate the costs resulted in an accurate estimate of uninsured costs. The MCVH included in UCC an undetermined amount of costs of patients with insurance coverage and costs related to services provided in prior periods.

Lastly, MCVH claimed \$7 million in SFY 1997 and \$8 million in SFY 1998 to treat inmates of the Virginia Department of Corrections. In August 2002, subsequent to our draft report, CMS issued a letter to State Medicaid Directors that clarified that DSH payments should not cover these expenditures.

We recommended that DMAS:

1. Refund \$6,324,796 to the Federal Government for the federal share of DSH overpayments that resulted from unallowable physician practice plan costs claimed for SFY 1997.
2. Require MCVH to revise its methodology for computing UCC to exclude physician practice plan costs and to include uninsured estimates based on its own experience for treating patients admitted without insurance in the year for which the DSH payment is made.
3. Ensure that MCVH complies with CMS's DSH policy regarding non-coverage of the costs of medical care provided to inmates of correctional facilities.

In its limited responses, DMAS and MCVH disagreed with our findings. The Virginia Commonwealth University (VCU) Health System Authority, which now operates MCVH, provided a lengthy response strongly disagreeing with our findings and recommendations. The VCU argued that physician practice plan costs were properly included as part of MCVH's UCC because the costs: 1) were contractual services incurred by MCVH, 2) were permitted under Medicare principles of cost reimbursement, and 3) could be defined as hospital costs under the Medicaid DSH statute and Medicaid regulations. The MCVH, therefore, concluded that the Office of Inspector General (OIG) should defer to Virginia's determination that physician practice plan costs are MCVH costs. The VCU also responded that MCVH's current method of calculating costs incurred for uninsured and Medicaid patients is an acceptable method; however, even using OIG's recommended methodology, MCVH was not overpaid for its UCC. Lastly, VCU asked that we exclude our discussion of state prisoner costs since this issue was not addressed to State Medicaid Directors until August 2002.

We continue to believe that the apparent purpose of section 1923 of the Act was to limit UCC to costs incurred for services provided by hospitals. The amounts MCVH included in its UCC for physician practice plan costs were not hospital incurred costs, but instead represented estimated costs incurred by Medical College of Virginia Physicians, a related but separate entity. Where appropriate, we made changes in the report to reflect the DMAS, MCVH, and VCU comments.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid

Page 3 – Thomas Scully

Audits at (410) 786-7104 or Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4470.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES
150 S. INDEPENDENCE MALL WEST
SUITE 316
PHILADELPHIA, PENNSYLVANIA 19106-3499

APR 24 2003

Report Number A-03-01-00222

Mr. Patrick W. Finnerty
Director
Department of Medical Assistance Services
Commonwealth of Virginia
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Dear Mr. Finnerty:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) final report entitled, **REVIEW OF MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS MADE BY VIRGINIA'S DEPARTMENT OF MEDICAL ASSISTANCE SERVICES TO THE MEDICAL COLLEGE OF VIRGINIA HOSPITALS FOR THE FISCAL YEARS ENDING JUNE 30, 1997 AND JUNE 30, 1998**. A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

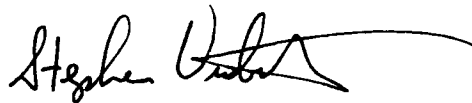
Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231) OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (see 45 CFR Part 5). As such, within 10 business days after the final report is issued, it will be posted on the Internet at <http://oig.hhs.gov>.

Page 2 – Mr. Patrick W. Finnerty

To facilitate identification please refer to report number A-03-01-00222 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephen Virbitsky", with a long horizontal flourish extending to the right.

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Ms. Sonia Madison
Regional Administrator
Centers for Medicare and Medicaid Services, Region III
The Public Ledger Building
150 S. Independence Mall West, Suite 216
Philadelphia, Pennsylvania 19106-3499

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICAID
DISPROPORTIONATE SHARE
HOSPITAL PAYMENTS MADE BY
VIRGINIA'S DEPARTMENT OF
MEDICAL ASSISTANCE SERVICES TO
THE MEDICAL COLLEGE OF
VIRGINIA HOSPITALS FOR THE
FISCAL YEARS ENDING
JUNE 30, 1997 AND JUNE 30, 1998**



**JANET REHNQUIST
Inspector General**

**APRIL 2003
A-03-01-00222**

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC at <http://oig.hhs.gov>

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.



EXECUTIVE SUMMARY

Background

Section 13621 of the Omnibus Budget Reconciliation Act (OBRA) of 1993 amended section 1923 of the Social Security Act (the Act) to limit disproportionate share hospital (DSH) payments. For state fiscal years (SFY) beginning after January 1, 1995, DSH payments to hospitals were limited to uncompensated care costs (UCC). The UCC were defined as costs of services to Medicaid patients, less the amount paid by the state under the non-DSH payment provisions; plus cost of uninsured patients, less any cash payments received from those patients.

The Department of Medical Assistance Services (DMAS) administers the Medicaid program in Virginia and is responsible for DSH payments. The Medical College of Virginia Hospitals (MCVH) provides inpatient and outpatient services to patients in the Richmond, Virginia area.

Objectives

The objectives of our review were to determine if DSH payments to MCVH for SFYs 1997 and 1998: (1) were calculated in accordance with the approved Medicaid state plan (state plan) and (2) did not exceed UCC as imposed by OBRA of 1993.

Summary of Findings

The DMAS made \$117 million in DSH payments to MCVH for SFY 1997 and \$80 million for SFY 1998. The DSH payments were calculated in accordance with the state plan. The MCVH claimed UCC of \$117 million and \$104 million for SFYs 1997 and 1998. However, we found that MCVH overstated its UCC by including costs that were not consistent with the apparent purpose of section 1923 of the Act. We identified unallowable costs included in UCC totaling over \$12 million for both SFYs 1997 and 1998. Unallowable costs consisted of physician practice plan costs incurred by a related entity. As a result, DSH payments for SFY 1997 exceeded UCC by \$12.2 million (\$6.3 million federal share). For SFY 1998, DSH payments did not exceed UCC.

We also were unable to determine the reasonableness of UCC totaling more than \$91 million for SFY 1997 and \$83 million for SFY 1998 because we do not believe that MCVH's methodology used to calculate the costs resulted in an accurate estimate of uninsured costs. The MCVH included in UCC an undetermined amount of costs of patients with insurance coverage and costs related to services provided in prior periods.

Lastly, MCVH claimed \$7 million in SFY 1997 and \$8 million in SFY 1998 to treat inmates of the Virginia Department of Corrections. In August 2002, subsequent to our draft report, the Centers for Medicare and Medicaid Services (CMS) issued a letter to State Medicaid Directors that clarified that DSH payments should not cover these expenditures.

We recommended that DMAS:

1. Refund \$6,324,796 to the Federal Government for the federal share of DSH overpayments that resulted from unallowable physician practice plan costs claimed for SFY 1997.
2. Require MCVH to revise its methodology for computing UCC to exclude physician practice plan costs and to include uninsured estimates based on its own experience for treating patients admitted without insurance in the year for which the DSH payment is made.
3. Ensure that MCVH complies with CMS's DSH policy regarding non-coverage of the costs of medical care provided to inmates of correctional facilities.

Synopsis of DMAS, MCVH, and Virginia Commonwealth University Health System Authority Responses

In its limited responses, DMAS and MCVH disagreed with our findings and concurred with MCVH's methodology for calculating UCC. The Virginia Commonwealth University (VCU) Health System Authority, which now operates MCVH, provided a lengthy response strongly disagreeing with our findings and recommendations. The VCU argued that physician practice plan costs were properly included as part of MCVH's UCC because the costs: 1) were contractual services incurred by MCVH, 2) were permitted under Medicare principles of cost reimbursement, and 3) could be defined as hospital costs under the Medicaid DSH statute and Medicaid regulations. The MCVH, therefore, concluded that the Office of Inspector General (OIG) should defer to Virginia's determination that physician practice plan costs are MCVH costs. The VCU also responded that MCVH's current method of calculating costs incurred for uninsured and Medicaid patients is an acceptable method; however, even using OIG's recommended methodology, MCVH was not overpaid for its UCC. Lastly, VCU asked that we exclude our discussion of state prisoner costs since this issue was not addressed to State Medicaid Directors until August 2002.

We continue to believe that the apparent purpose of section 1923 of the Act was to limit UCC to costs incurred for services provided by hospitals. The amounts MCVH included in its UCC for physician practice plan costs were not hospital incurred costs, but instead represented estimated costs incurred by Medical College of Virginia Physicians, a related but separate entity. Where appropriate, we made changes in the report to reflect the DMAS, MCVH, and VCU comments. We included the comments, in their entirety, in APPENDIX C. Their comments and the OIG response are summarized in the report.

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INTRODUCTION

BACKGROUND

Title XIX of the Social Security Act (the Act) authorizes federal grants to states for Medicaid programs that provide medical assistance to qualified low-income needy people. Each state Medicaid program is administered by the state in accordance with an approved state plan. While the state has considerable flexibility in designing its state plan and operating its Medicaid program, it must comply with broad federal requirements. At the federal level, the program is administered by the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration, an agency of the Department of Health and Human Services. In Virginia, the Department of Medical Assistance Services (DMAS) administers the Medicaid program and is responsible for disproportionate share hospital (DSH) payments.

The Federal Government and states share in the cost of the program. States incur expenditures for medical assistance payments to medical providers who furnish care and services to Medicaid beneficiaries. The Federal Government pays its share of medical assistance expenditures according to a defined formula. That share is known as the federal medical assistance percentage (FMAP) and ranges from 50 percent to 83 percent, depending upon each state's relative per capita income. The FMAP rate in Virginia is about 52 percent. The federal payment for its share of medical cost is referred to as federal financial participation (FFP).

The Omnibus Budget Reconciliation Act (OBRA) of 1981 established the DSH program by adding section 1923 to the Act. Section 1923 required state Medicaid agencies to make additional payments to hospitals serving disproportionate numbers of low-income patients with special needs. States had considerable flexibility to define DSH hospitals under sections 1923(a) and (b) of the Act. States receive allocations of DSH funds as set forth by federal statute. The DSH expenditures are eligible for FFP. Subject to state allocations, the Federal Government reimburses states for DSH expenditures based upon the applicable Medicaid matching percentage. States report Medicaid expenditures on the *Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program* (Form CMS-64).

The OBRA of 1993 established additional DSH parameters by amending section 1923 of the Act to limit DSH payments to the amount of a hospital's incurred uncompensated care costs (UCC). Under section 1923(g), the UCC was limited to the costs of medical services provided to Medicaid and uninsured patients less payments received for those patients excluding Medicaid DSH payments. The specific language contained in the Act, as amended, is as follows:

“Section 1923...

(g) Limit on Amount of Payment to Hospital.--

(1) Amount of Adjustment subject to uncompensated costs.---

- (A) In General---A payment adjustment during a fiscal year shall not be considered to be consistent with...respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.”

For state fiscal years (SFY) beginning between July 1, 1994 and January 1, 1995, payments to public hospitals were limited to 100 percent of UCC with a special provision that allowed payments of up to 200 percent of UCC to those public hospitals qualifying as high DSH hospitals. For SFYs beginning on or after January 1, 1995, payments to all hospitals were limited to 100 percent of UCC.

According to the Virginia state plan, DSH payments are calculated using a formula based on the type of hospital--Type One or Type Two--and the hospital's Medicaid utilization percentage. Type One consists of the two state-owned teaching hospitals, the Medical College of Virginia Hospitals (MCVH) and the University of Virginia Medical Center; Type Two includes all other hospitals. Under the state plan's DSH payment formula, a Type One hospital would receive about 13 times more in DSH payments than a Type Two hospital would receive for serving the same volume of Medicaid patients. The state plan also limits DSH payments to a hospital's UCC as established by OBRA of 1993. Specifically, the state plan states:

- “A payment adjustment during a fiscal year shall not exceed the sum of:
- (a) Medicaid allowable costs incurred during the year less Medicaid payments, net of disproportionate share payment adjustments, for services provided during the year, and
 - (b) Costs incurred in serving persons who have no insurance less payments received from those patients or from a third party on behalf of those patients....”

Located in Richmond, Virginia, with 720-staffed beds, MCVH is one of the nation's largest university-affiliated teaching hospitals. The Virginia Commonwealth University (VCU) Health Systems Authority now operates the MCVH.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of our review were to determine if DSH payments made to MCVH for SFYs 1997 and 1998 (1) were calculated in accordance with the approved state plan and (2) did not exceed the UCC as imposed by OBRA of 1993.

To accomplish our first objective, we reviewed DSH payment data at DMAS and reconciled DSH payments to amounts claimed on Form CMS-64. For each SFY

reviewed, DMAS made DSH payments to eligible hospitals over several years. Therefore, we reconciled and matched DSH payments to the SFY to which they pertained. For example, for SFY 1997, DMAS made \$117,221,099 (\$60,403,235 FFP) in DSH payments to MCVH from September 26, 1996 to July 27, 2000. For SFY 1998, DMAS made \$80,079,718 (\$41,266,181 FFP) in DSH payments to MCVH from September 18, 1997 to July 27, 2000. Finally, we compared DSH payments to MCVH's claimed UCC to determine whether DMAS computed DSH payments in accordance with the state plan.

To accomplish our second objective, we obtained and evaluated supporting documentation for selected categories of claimed UCC for each SFY. The MCVH claimed UCC of \$117,276,061 and \$104,399,548 in SFYs 1997 and 1998. Documentation included MCVH's financial statements, accounting records, indigent care and Medicaid cost reports, and other financial data provided as support for claimed UCC. We also selected a non-statistical sample of 360 cases to determine whether certain categories of claimed costs met the federal requirements to be included as part of MCVH's UCC. We chose a non-statistical sample because we would not project any results from a statistical sample. This non-statistical sample allowed us to disclose the attributes of the charges. Only through a recomputation of the cost report could we determine the effect of questionable charges. Therefore, we determined that a statistical sample selection would not be efficient or provide a reliable projection.

Our audit was performed in accordance with generally accepted government auditing standards. Our review of MCVH's internal control structure was limited to obtaining an understanding of the process used to prepare MCVH's UCC schedule. Our field work was performed at DMAS and MCVH in Richmond, Virginia.

FINDINGS

The DMAS made \$117,221,099 in DSH payments to MCVH for SFY 1997 and \$80,079,718 for SFY 1998. The DSH payments were calculated in accordance with the state plan. The MCVH claimed UCC of \$117,276,061 and \$104,399,548 for SFYs 1997 and 1998.

We found that MCVH overstated its UCC by including costs that were not consistent with the apparent purpose of section 1923 of the Act. We identified unallowable costs included in UCC totaling \$12,331,351 for SFY 1997 and \$12,792,798 for SFY 1998. As a result, DSH payments to MCVH exceeded its actual UCC for SFY 1997 by \$12,276,389 (\$6,324,796 FFP). For SFY 1998, DSH payments did not exceed UCC (APPENDIX B). Overstated UCC resulted from the following:

- Medical College of Virginia (MCV) Physicians costs of \$12,331,351 for SFY 1997 and \$12,792,798 for SFY 1998. Federal statute limits UCC to cost incurred by MCVH for furnishing hospital services. The amounts claimed, however, represent estimated costs incurred by MCV Physicians for treating

indigent patients. Thus the costs were not MCVH incurred costs. The MCV Physicians and MCVH were separate legal entities during SFYs 1997 and 1998.

We were unable to determine the reasonableness of UCC totaling \$91,310,489 for SFY 1997 and \$83,129,960 for SFY 1998 because the MCVH claimed an undetermined amount of unallowable costs. Unresolved UCC included the following:

- Indigent care costs of \$80,802,832 for SFY 1997 and \$71,609,244 for SFY 1998. Contrary to federal statute and the state plan, many patients that MCVH classified as indigent had health insurance and a significant portion of indigent care charges related to services provided in prior years.
- Bad debt costs of \$10,507,657 for SFY 1997 and \$11,520,716 for SFY 1998. Many bad debt accounts showed health insurance coverage. Also, MCVH did not offset payments received for bad debt accounts.

Lastly, MCVH included in its UCC the costs of providing hospital services to prisoners of the Virginia Department of Corrections. Costs claimed for medical services to prisoners were \$6,975,200 for SFY 1997 and \$7,628,683 for SFY 1998. In August 2002, CMS issued a State Medicaid Director's letter that clarified that DSH payments should not cover these expenditures. See APPENDIX A for a detailed listing of adjustments and unresolved costs.

OVERSTATED UNCOMPENSATED CARE COST

The UCC is defined as the sum of (1) the costs of services to Medicaid patients, less the amount paid by the state under the non-DSH payment provisions, plus (2) the costs of uninsured patients, less any cash payments made by them. The MCVH claimed UCC totaling \$117,276,061 and \$104,399,548 for SFYs 1997 and 1998, respectively. However, we found that MCVH overstated its UCC by including costs that were not consistent with the apparent purpose of section 1923 of the Act. We identified unallowable costs included in UCC totaling \$12,331,351 for SFY 1997 and \$12,792,798 for SFY 1998.

Medical College of Virginia Physicians Costs

The MCVH included in its UCC, MCV Physicians costs of \$12,331,351 for SFY 1997 and \$12,792,798 for SFY 1998. During our audit period, MCV Physicians was a non-profit group practice organization comprised primarily of physician faculty employees of the VCU School of Medicine.

According to federal law, only costs incurred by a hospital may be included as part of its UCC. Specifically, section 1923 of the Act states:

- “(g) Limit on Amount of Payment to Hospital.--
- (1) Amount of Adjustment subject to uncompensated costs.---

(A) In General--- A payment adjustment during a fiscal year shall not be considered to be consistent with...respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.” (Underline added)

In an August 1994 State Medicaid Director letter, CMS provided its interpretation of the OBRA of 1993 DSH provisions. In regard to cost of services under the DSH limit, CMS stated that it would “...permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement.” The CMS believed this interpretation was reasonable because “...it provides states with a great deal of flexibility up to a maximum standard that is widely known and used in the determination of hospital costs.”

The amounts included in UCC represented estimated costs incurred by MCV Physicians for treating indigent patients. The costs were not MCVH’s costs incurred for furnishing hospital services. The MCV Physicians and MCVH were separate legal entities during SFYs 1997 and 1998. Further, these costs are unallowable under the Medicare principles of cost reimbursement. Therefore, these costs should not be included as part of MCVH’s UCC.

UNRESOLVED UNCOMPENSATED CARE COST

We were unable to render an opinion on UCC totaling \$91,310,489 for SFY 1997 and \$83,129,960 for SFY 1998. The MCVH officials stated that these costs represented the cost of treating uninsured indigent and non-indigent patients. However, our review showed that, contrary to federal statute, many of these patients had health insurance coverage and many of the charges related to services provided in prior years. Also, MCVH did not offset payments received.

Indigent Care Costs

The MCVH included in its UCC indigent care costs of \$80,802,832 for SFY 1997 and \$71,609,244 for SFY 1998. According to MCVH officials, indigent care costs represented the estimated costs of providing medical care to uninsured patients who qualify as indigent. A person is indigent if family income and assets do not exceed state limits. A cost sharing or copayment by an indigent patient may be required based on income level.

To determine uninsured indigent patient costs, MCVH computed total indigent care costs through the indigent care cost report. First, total allowable and allocable costs were

determined based on MCVH's Medicare cost report. Next, indigent patients were apportioned their share of overall costs based on per diem cost amounts or percentages of costs compared to charges. Indigent charges represented write-off adjustments for unpaid charges for indigent patient services. The MCVH then deducted an estimate of copayments by indigent patients. Finally, MCVH estimated that approximately 90 percent of the net indigent costs represented uninsured patient costs and reported that amount on its UCC schedule.

Our review of indigent care costs found that, contrary to federal statute, many patients classified as indigent had health insurance and a significant portion of indigent care charges related to services provided in prior years. During our review, we requested that MCVH remove those patients with health insurance from its estimates of indigent care costs, but MCVH officials declined. Therefore, we are not expressing an opinion on indigent care costs claimed as part of UCC because we do not believe that MCVH's methodology used to calculate the costs resulted in accurate estimates of uninsured costs.

Cost of Insured Patients Included in Indigent Care Cost

The MCVH's estimate of uninsured indigent costs--about 90 percent of total indigent care costs--was developed from data applicable to the University of Virginia Medical Center. This estimate had no direct relation to MCVH's own experience in treating uninsured patients. In support of the estimate, MCVH provided us with a database of indigent charges that were used to develop indigent care costs. The database identified patients by payer-type. For example, self-pay category 1 (indigent patient status verified) and category 2 (indigent status not verified, patient charges sent to collection agency) represented about 94 percent of total indigent charges. The remaining 6 percent of charges related to patients insured under such plans as Medicare, Medicaid, CHAMPUS (health insurance for members of the armed forces and their dependents), and various commercial insurers. The database of indigent charges made it appear that MCVH, by including only 90 percent of indigent care cost in its UCC, may have underestimated its uninsured patient costs. However, our review of a non-statistical sample drawn from the 94 percent of indigent charges in self-pay status showed that many of these indigent patients had health insurance coverage for the services received.

We reviewed 150 indigent care charges each year (50 inpatient, 100 outpatient). Of the 150 charges in SFY 1997, 67 charges totaling \$247,545 represented 52 patients (25 inpatient, 27 outpatient) classified by MCVH as self-pay or uninsured. We found that 21 of these patients (15 inpatient, 6 outpatient) had health insurance coverage that made payments for the health services rendered. Specifically, we found that 13 percent of self-pay charges totaling \$32,612 represented claims that also showed third-party payments. For SFY 1998, 73 indigent care charges totaling \$176,871 represented 57 self-pay patients (30 inpatient, 27 outpatient). We found that 16 of these patients (10 inpatient, 6 outpatient) had health insurance coverage. As a result, 18 percent or \$31,082 of the indigent charges represented claims that also showed third-party payments.

Section 1923(g)(1)(A) of the Act limits a hospital's UCC to the unreimbursed cost of treating patients who are either eligible for medical assistance or have no health insurance. A hospital's DSH payments are limited to its UCC. The state plan also specifies that DSH payments shall not exceed costs incurred in serving persons who have no insurance less payments received from those patients or from a third party. In a January 1995 letter to the State Medicaid Director's Association, CMS stated that if the patient has insurance coverage for the service provided, but the full cost of the service was not reimbursed, the unreimbursed cost of the services would not be included in the calculation of the DSH payment limit. The following case from our sample illustrates what CMS did not intend the DSH program to cover.

- A patient was admitted for a 3-day hospital stay resulting in charges of \$5,158.95. The patient was identified in self-pay category 1. However, MCVH received \$2,363.67 from the CHAMPUS insurance program, leaving a balance of \$2,795.28 in unpaid charges. This included \$75 for the \$25 per day differential between the private room rate billed by MCVH and the CHAMPUS allowed rate. Of the \$2,795.28 in unpaid charges, MCVH classified \$2,017.48 as indigent care. The MCVH included the costs of these services in its UCC.

During our audit field work, we requested that MCVH remove those patients with health insurance from its estimates of indigent care costs, but MCVH officials declined. Therefore, we are not expressing an opinion on indigent care costs claimed as part of UCC because we do not believe that MCVH's methodology used to calculate the costs resulted in accurate estimates of uninsured costs.

Indigent Care Charges Related to Services Provided in Prior Years

We found that approximately 30 percent of total indigent care charges had dates of service earlier than the year for which DSH payments were claimed. Some indigent charges were more than 5 years old. The MCVH staff noted that, at admission, the patient record is queried to determine if unpaid charges exist. The MCVH included in its UCC calculation old unpaid charges as indigent care if current charges were deemed indigent. We believe that MCVH's practice of including costs from prior periods in its UCC calculation is not in compliance with section 1923(g)(1)(A) of the Act that limits DSH payments to hospitals for a fiscal year to "...costs incurred during the year of furnishing hospital services...." The January 1995 letter to the State Medicaid Director's Association provided CMS's interpretation of this section of the Act. Specifically, CMS stated, "It is our belief that this language indicates that Congress intended States to match costs for hospital services provided during a particular year to payments received relating to those services provided for a particular year." The following example from our sample illustrates MCVH's practice of including costs from prior periods into current UCC.

- A patient was admitted in November 1991 and incurred \$9,924.02 in charges for an 11-day stay. Between February 1994 and April 1997, MCVH received \$2,087.35 in patient payments. In March 1998, MCVH determined that \$7,116.67 in charges related to the treatment provided in 1991 was indigent care.

The MCVH converted the charges to costs based on per diem rates and cost to charge ratios developed from its SFY 1998 cost report and included the cost in its UCC for SFY 1998.

Because we found that a significant portion of indigent care charges related to services provided in prior years, we are not expressing an opinion on indigent care costs claimed as part of UCC. The MCVH's UCC schedules should have included only those unreimbursed indigent care costs of uninsured patients for SFYs 1997 and 1998.

Bad Debt Costs

The MCVH included in its UCC bad debt costs of \$10,507,657 for SFY 1997 and \$11,520,716 for SFY 1998. According to MCVH officials, bad debt costs represented the cost of treating uninsured patients who do not qualify as indigent. The MCVH computed these costs by first taking all charges written off each year as the allowance for bad debts. The MCVH then subtracted those charges for patients who qualify as indigent. Finally, MCVH applied a ratio of cost to charges to the remaining charges to determine bad debt write-off costs.

Our review of a non-statistical sample of 60 bad debt accounts found that many accounts showed health insurance coverage. We also found that MCVH did not offset payments received for bad debt accounts. We are not expressing an opinion on bad debt costs claimed as part of UCC because we do not believe that MCVH's methodology used to calculate the costs resulted in an accurate estimate of uninsured costs. The MCVH's estimate of bad debt costs should have included only the current costs net of payments received for treating those patients with no insurance.

Insured Patients Included in Bad Debt Cost

We found that, contrary to federal law, MCVH included in UCC bad debt costs related to patients with insurance coverage. Specifically, MCVH was not in compliance with section 1923(g)(1)(A) of the Act that limits DSH payments to hospitals during a fiscal year to the costs incurred during the year of furnishing hospital services to individuals who have no health insurance for the services provided.

In SFY 1997, 16 percent of the bad debt charges used for the UCC calculation pertained to patients who had health insurance coverage. In SFY 1998, 21 percent related to patients with health insurance coverage. In addition, in 17 (10 in SFY 1997 and 7 in SFY 1998) of the 60 sample cases reviewed, patients were identified as self-pay. We found that 6 of the 17 cases showed third-party payments prior to the write-off of bad debt charges.

Payments Not Offset Against Bad Debts

Contrary to federal law, MCVH did not offset payments received before including bad debt costs into its UCC calculation. Section 1923(g)(1)(A) of the Act limits UCC to the

costs of furnishing hospital services to individuals who have no health insurance, net of payments received. We found that subsequent to writing off the charges as bad debts, MCVH, in 17 of 30 cases for SFY 1997 and 15 of 30 cases for SFY 1998, recovered all unpaid charges.

Prisoner Medical Cost

The MCVH included in its UCC the costs of providing hospital services to prisoners of the Virginia Department of Corrections. Costs claimed for medical services to prisoners were \$6,975,200 for SFY 1997 and \$7,628,683 for SFY 1998. The costs of these services were also reimbursed to MCVH through a contract with the Virginia Department of Corrections. Virginia's state plan was silent on whether the cost for services provided to inmates is included in UCC.

Federal regulations prohibit the use of federal Medicaid funds for services provided to inmates of public institutions. Specifically, 42 CFR 441.13 states:

“(a) FFP is not available in expenditures for services for—
(1) Any individual who is in a public institution....”

Federal regulations at 42 CFR 435.1009 state that, “*Inmate of a public institution* means a person who is living in a public institution.”

In August 2002, subsequent to our draft report, CMS issued a letter to State Medicaid Directors providing policy clarification on several aspects of the DSH program. One aspect was the inclusion of medical services provided to inmates in DSH calculations. The letter states:

“Inmates of correctional facilities are wards of the State. As such, the State is obligated to cover their basic economic needs (food, housing, and medical care) because failure to do so would be in violation of the eighth amendment of the Constitution. Therefore, because these individuals have a source of third party coverage, they are not uninsured, and the State cannot make DSH payments to cover the costs of their care.”

Although CMS did not distribute this policy clarification to every state on the exclusion of prisoner costs until August 2002, we believe CMS never intended to approve state plan amendments that allowed payments that were properly the obligation of the state or a subdivision of government (i.e., counties). Virginia's state plan was silent on the inclusion of costs for services provided to inmates. We are reporting this condition to alert CMS to the extent of Virginia's use of the Medicaid DSH program to pay for the costs of medical care to inmates and to recommend that DMAS ensure that MCVH complies with CMS's policy.

CONCLUSION AND RECOMMENDATIONS

Our review determined that for SFYs 1997 and 1998, the DSH payments made to MCVH were calculated in accordance with the state plan. We found, however, that MCVH overstated its UCC by including costs that were not consistent with the apparent purpose of section 1923 of the Act. We identified unallowable costs included in UCC totaling \$12,331,351 for SFY 1997 and \$12,792,798 for SFY 1998. Unallowable costs consisted of physician practice plan costs incurred by a related entity. As a result, DSH payments for SFY 1997 exceeded UCC by \$12,276,389 (\$6,324,796 FFP). For SFY 1998, DSH payments did not exceed UCC.

We also were unable to render an opinion on UCC totaling \$91,310,489 for SFY 1997 and \$83,129,960 for SFY 1998 because the costs reported included an undetermined amount of costs (1) for patients with health insurance coverage and (2) that were not offset against payments received. The MCVH's accounting system had the capability to remove unallowable costs from UCC. During our review we requested that MCVH revise its UCC to include only the current net cost of services furnished to patients admitted with no insurance, but MCVH declined.

Lastly, MCVH claimed \$7 million in SFY 1997 and \$8 million in SFY 1998 for the medical costs to treat inmates of the Virginia Department of Corrections. In August 2002, CMS issued a State Medicaid Director's letter that clarified that DSH payments should not cover the medical costs of state prisoners.

We recommended that DMAS:

1. Refund \$6,324,796 to the Federal Government for the federal share of DSH overpayments that resulted from unallowable physician practice plan costs claimed for SFY 1997.
2. Require MCVH to revise its methodology for computing UCC to exclude physician practice plan costs and to include uninsured estimates based on its own experience for treating patients admitted without insurance in the year for which the DSH payment is made.
3. Ensure that MCVH complies with CMS's DSH policy regarding non-coverage of the costs of medical care provided to inmates of correctional facilities.

DMAS, MCVH, AND VCU COMMENTS AND OIG RESPONSE

The DMAS and MCVH disagreed with our findings and concurred with MCVH methodology for calculating UCC. The VCU, which now operates MCVH, strongly disagreed with our findings and provided a lengthy response that can be found in APPENDIX C. Its response focused on the questioned physician practice plan costs and the methodology for computing uninsured patient costs.

MCV Physicians Costs

VCU Comments

The VCU responded that the Office of Inspector General's (OIG) finding with respect to the MCV Physicians costs was incorrect for a number of reasons. First, VCU contended that MCVH incurred, through a contractual arrangement, substantial and necessary costs for the provision of the physician component of hospital services to indigent patients. The VCU believed that the costs of physician services were reimbursable under Medicare principles of cost reimbursement and also fit within the statutory description of the hospital-specific DSH cap and administrative guidance provided by CMS. The MCVH stated that OIG specifically included costs associated with the professional services provided by hospital-based physicians at Kern Medical Center¹ to that hospital's UCC and sees no reason why OIG should exclude MCVH's. In addition, VCU responded that to the extent that physician costs incurred by hospitals are not specifically mentioned in either the statute or guidance, CMS granted broad flexibility to states in terms of defining costs includable in the hospital-specific DSH cap, and the states have sufficient flexibility to include physician costs as a component of hospital services.

OIG Response

We disagree with VCU's position regarding the inclusion in UCC of MCV Physicians costs. We believe that the explicit language of the DSH statute, CMS interpretation of the statute, and Medicare cost principles support our position that MCV Physicians costs should not be included as part of MCVH's UCC.

Section 1923 (g)(1)(A) of the Act states that a DSH payment shall not exceed, "...the costs incurred during the year of furnishing hospital services...by the hospital..." By this language we believe that the Congress intended DSH payments to compensate a hospital for costs it incurred for furnishing hospital services.

In August 1994, CMS provided its interpretation of the DSH statute to State Medicaid Directors. The CMS allowed states flexibility in defining allowable cost of hospital services subject to the DSH limit, "...as long as the costs determined under such a definition do not exceed the amounts that would be allowable under Medicare principles of cost reimbursement." The CMS believed its interpretation was reasonable because its maximum standard (Medicare cost principles) was, "...widely known and used in the determination of hospital costs."

The MCVH used its Medicare cost report as the basis of its indigent care cost report. The MCV Physicians costs, however, were not included in MCVH's Medicare cost report but instead were compiled separately from estimated costs supplied by MCV Physicians and

¹ *Audit of California's Medicaid Inpatient Disproportionate Share Hospital Payment for Kern Medical Center, Bakersfield, California, State Fiscal Year 1998* (HHS/OIG Report Number A-09-01-00098, September 17, 2002).

included as an additional cost in MCVH's UCC report. The costs were not included in MCVH's Medicare cost report for good reason--the costs do not meet Medicare cost principles for determining hospital costs. In fact, physician costs must meet specific requirements to be included in a hospital's Medicare cost report.

Hospitals are reimbursed for costs incurred in the compensation of provider-based physicians (42 CFR 415.60). However, reimbursement is only made for the portion of physician time spent on non-patient-related services to the hospital (provider component). Physician time spent on patient-related services (professional component) is not allowable. The professional services rendered by a physician are not reimbursable through the cost report because the Medicare Part B carrier reimburses them based on the applicable fee schedule amount (42 CFR 414.21).²

There are additional rules applicable to physician services in teaching settings that would apply to MCVH as a teaching hospital. Specifically, a teaching hospital *may elect* to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of fee schedule payments that might otherwise be made for these services (42 CFR 415.160). Physician services would include those provided by MCV Physicians. The MCVH, however, did not make this election. Therefore, physician services provided by MCV Physicians to Medicare beneficiaries were reimbursed to MCV Physicians on a fee schedule basis. Consequently, MCV Physicians costs for providing these services are not includable on MCVH's cost report.

The circumstances with respect to the physician services at Kern Medical Center differed significantly from those surrounding the physician services claimed by MCVH. In the case of Kern Medical Center, a county-owned hospital, provider-based physicians employed by the hospital provided the services. Under California law, Kern Medical Center was permitted to employ physicians, making costs associated with professional medical services provided by those physicians a recognizable hospital cost. Unlike MCVH, Kern Medical Center included the professional component of the costs in the non-reimbursable category of its Medicare cost report. Accordingly, the OIG recognized the costs associated with the professional medical services provided by those physicians to be hospital-incurred costs and included the costs in the calculation of the UCC limit.

Unresolved UCC

VCU Comments

The VCU responded that MCVH's UCC calculations were reasonable estimates of UCC incurred by the hospital for treating patients without insurance. The MCVH adjusted the costs in each category to exclude costs associated with insured persons. The VCU stated that MCVH included costs of services provided in prior years because it could not verify

² An exception to the basic rule that Medicare makes payment to the provider who provides the service occurs where the payment is made to an employer. Specifically, Medicare may pay a physician's employer if the physician is required, as a condition of employment, to turn over to the employer the fees for his or her services (42 CFR 424.80(b)).

their indigent status until the year the costs were claimed. The VCU acknowledged that MCVH did not offset bad debt costs by payments received. Overall, VCU stated that as was the case with physician costs, MCVH's approach to calculating UCC, accepted by Virginia, was reasonable given the broad flexibility explicitly granted to states in interpreting the hospital-specific DSH cap. Finally, VCU stated that it recalculated MCVH's UCC using OIG's strict interpretations. According to VCU its recalculations resulted in higher estimates of UCC and, therefore, confirm that no overpayment was made to MCVH in SFYs 1997 and 1998.

OIG Response

We continue to believe that MCVH should revise its methodology of computing UCC to include only Medicaid losses and the current net cost of hospital services furnished to patients with no insurance. This would be consistent with DSH statute and the state plan to limit DSH payments to a hospital to its Medicaid losses and costs incurred (net of payments received) for patients who have no insurance. Our review of the two major categories of MCVH's UCC—indigent care costs and bad debts—showed that many of the indigent and bad debt patients had health insurance coverage, many of the indigent costs claimed related to services provided in prior years, and MCVH did not offset payments received on bad debt accounts. The VCU did not dispute these findings, yet it continues to insist that MCVH's approach to calculating UCC was reasonable.

During our on-site field work, we requested that MCVH remove those patients with health insurance from its estimates of indigent care and bad debt costs, but MCVH officials declined. For the purposes of its response to our draft report, VCU stated that MCVH recomputed its UCC using OIG's interpretations and the recalculated UCC resulted in higher estimates. We have not audited MCVH's recalculated UCC and, therefore, cannot comment on whether it complies with the DSH statute. However, to the extent that MCVH based its revised UCC on the costs to treat patients classified as indigent or bad debt, we believe that the possibility exists that the revised estimates would include patients with insurance coverage. This is because indigent status only refers to the patient's level of income and assets and not whether or not the patient has health insurance coverage. Likewise, our review found that MCVH's bad debt category included patients with health insurance. We believe DMAS should review MCVH's revised UCC calculation to ensure it complies with the DSH statute.

Prisoner Medical Costs

VCU Comments

The VCU asked that OIG remove any reference to its inclusion of the costs of treating inmates of Virginia's Department of Corrections in MCVH's UCC calculation. The VCU believed the CMS policy letter addressing prisoner costs was sufficient.

OIG Response

Subsequent to our draft report, CMS issued a policy clarification letter to states regarding the non-coverage of prisoner health care cost. Although CMS issued this policy clarification subsequent to our draft report, we believe CMS never intended to approve a state plan amendment that would include payments that were properly the obligation of the state or a subdivision of government (i.e., counties). We kept this finding in the final report because MCVH was including prisoner costs in its UCC and we are recommending that DMAS ensure that MCVH complies with CMS's policy.

APPENDIX A

Summary Schedule
Audit Adjustments to Uncompensated Care Costs

State Fiscal Year 1997

Cost Element	Claimed UCC	OIG Adjustments	Adjusted UCC	Unresolved UCC
Non-HMO Patients	(\$1,705,430)		(\$1,705,430)	
HMO Patients	\$7,421,884		\$7,421,884	
Outpatient Laboratory	\$27,291		\$27,291	
Pediatric Transplant	\$17,277		\$17,277	
Medicaid Patient Costs	\$5,761,022		\$5,761,022	
Indigent Care	\$80,802,832		\$80,802,832	\$80,802,832
Physician Practice Plan	\$12,331,351	\$12,331,351		
Bad Debt Write-Off	\$10,507,657		\$10,507,657	\$10,507,657
VA Dept. of Corrections	\$6,975,200		\$6,975,200	
State/Local Hospital Program	\$897,999		\$897,999	
Uninsured Patient Costs	\$111,515,039	\$12,331,351	\$99,183,688	\$91,310,489
TOTAL UCC	\$117,276,061	\$12,331,351	\$104,944,710	\$91,310,489

State Fiscal Year 1998

Cost Element	Claimed UCC	OIG Adjustments	Adjusted UCC	Unresolved UCC
Non-HMO Patients	(\$7,075,186)		(\$7,075,186)	
HMO Patients	\$6,777,506		\$6,777,506	
Outpatient Laboratory	\$142,877		\$142,877	
Pediatric Transplant	\$(65,161)		\$(65,161)	
Medicaid Patient Costs	(\$219,964)		(\$219,964)	
Indigent Care	\$71,609,244		\$71,609,244	\$71,609,244
Physician Practice Plan	\$12,792,798	\$12,792,798		
Bad Debt Write-Off	\$11,520,716		\$11,520,716	\$11,520,716
VA Dept. of Corrections	\$7,628,683		\$7,628,683	
State/Local Hospital Program	\$1,068,071		\$1,068,071	
Uninsured Patient Costs	\$104,619,512	\$12,792,798	\$91,826,714	\$83,129,960
TOTAL UCC	\$104,399,548	\$12,792,798	\$91,606,750	\$83,129,960

APPENDIX B**Summary Schedule
Computation of Excess Payments**

	1997		1998	
	Total Computable	Federal Share	Total Computable	Federal Share
DSH Payments	\$117,221,099	\$60,403,235	\$80,079,718	\$41,266,181
Less: Adjusted UCC	\$104,944,710	\$54,078,439	\$91,606,750	\$47,206,061
Excess DSH Payments	\$12,276,389	\$6,324,796	\$0	\$0

Average Federal Share: SFY 1997 = 51.52%; SFY 1998 = 51.53%

APPENDIX C

DMAS, MCVH, and VCU COMMENTS



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

PATRICK W. FINNERTY
DIRECTOR

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November 19, 2002

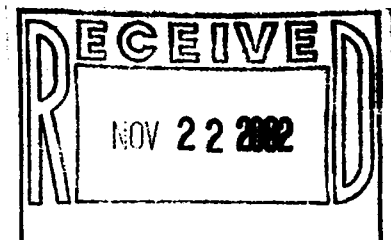
Mr. Stephen Virbitsky
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of the Inspector General
Office of Audit Services
150 S. Independence Mall West, Suite 316
Philadelphia, Pennsylvania 19106-3499

Dear Mr. Virbitsky:

This letter is a follow up to my letter of November 13, 2001 regarding the OIG draft reports which I shall refer to collectively as "Review of Medicaid Disproportionate Share Hospital Payments made by Virginia's Department of Medical Assistance Services to the Medical College of Virginia Hospitals (MCVH) and the University of Virginia Medical Center (UVA Medical Center) for Fiscal Years Ending June 30, 1997 and June 30, 1998".

We agree with the findings and conclusions of the responses submitted by both MCVH and the UVA Medical Center, and we request that the OIG revise its proposed adjustments to be consistent with these responses and their respective conclusions. As acknowledged in the draft reports, disproportionate share hospital (DSH) payments made by Virginia's Department of Medical Assistance Services were in accordance with our Medicaid State Plan which has been appropriately reviewed and approved by the federal Centers for Medicare and Medicaid Services. We not only have confidence that Virginia's existing methods for determining uncompensated care costs and calculating DSH payments are consistent with our State Plan and related federal requirements, we also believe that the calculations included in the responses by MCVH and the UVA Medical Center confirm the validity of these methods.

In light of the differences between the draft reports and the responses, it is our recommendation that a meeting be scheduled with this office to review the responses prior to your completion of final reports. By this letter, I request that you accept this recommendation and that we schedule a meeting at our mutual convenience.



Thank you for consideration of our responses as well as our request for a meeting.
If you have any questions, please contact me at (804) 786-8099 or Stanley Fields at (804) 786-5590.

Sincerely,

A handwritten signature in black ink, appearing to read "P. W. Finnerty", written in a cursive style.

Patrick W. Finnerty
Director

Cc: Manju Ganeriwala
Stanley Fields
Dom Puleo, MCV Hospitals/VCUHS
Larry Fitzgerald, UVA Medical Center



V i r g i n i a C o m m o n w e a l t h U n i v e r s i t y

MCV Campus

Health System

MCV Hospitals and Physicians

**VCU Health System
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November 13, 2002

Mr. Stephen Virbitsky
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services
150 S. Independence Mall West, Suite 316
Philadelphia, PA 19106-3499

Re: Common Identification Number A-03-01-0222 (Review of Medicaid Disproportionate Share Hospital Payments Made by Virginia's Department of Medical Assistance Services to the Medical College of Virginia Hospitals for the Fiscal Years Ending June 30, 1997 and June 30, 1998)

Dear Mr. Stephen Virbitsky:

In connection with the audit by the Department of Health and Human Services Office of Inspector General (OIG) of disproportionate share hospital (DSH) payments to the Medical College of Virginia Hospitals (MCVH) for State Fiscal Years (SFYs) 1997 and 1998, this letter contains our response to the Department of Medical Assistance Services related to the findings contained within the draft report dated August 2002 (the **OIG Draft Report**). Thank you for the opportunity to review and comment on the draft report. The VCU Health System shares the **OIG's** commitment to ensuring that the Medicaid program is administered with integrity. However, we do not believe that the recommendations contained in the **OIG Draft Report** are necessary.

The **OIG Draft Report** contained two primary findings. First, the **OIG** found that MCVH overstated its uncompensated care costs (UCC) by "including costs that did not meet Federal guidelines." Second, the **OIG** noted that they were "unable to determine the reasonableness of UCC ... because we do not believe that MCVH's methodology used to calculate the costs resulted in an accurate estimate of uninsured costs." The **OIG** also found that the DSH payments were calculated in accordance with the State Plan.

We are comforted by the **OIG's** finding that the DSH payments were calculated in accordance with Virginia's approved State Plan, but otherwise disagree with the **OIG's** findings. We have substantial confidence in our existing methods for determining UCC

and calculating DSH payments and note that Virginia's State Plan was reviewed and approved by the Centers for Medicare and Medicaid Services (CMS). We firmly believe that our existing methodology correctly calculates UCC.

The VCU Health System Authority, which now operates MCVH, has reviewed the OIG Draft Report and a comprehensive and thorough response is attached to this letter. We particularly want to emphasize that, as explained in more detail in the attached, even if all of the OIG's recommendations were adopted, MCVH would still have had sufficient UCC to justify all of the DSH payments made for SFYs 1997 and 1998. We believe this analysis confirms the validity of the Department's existing methods for estimating UCC and calculating DSH payments.

Once again, thank you for the opportunity to review and comment on the OIG's Draft Report. If you have any questions or need additional information, please feel free to contact Dominic Puleo at (804) 828-4633.

Sincerely,

A handwritten signature in black ink, appearing to read "Dom Puleo", written in a cursive style.

Dominic J. Puleo
Executive Vice President/Chief Financial Officer
Virginia Commonwealth University Health System
MCV Hospitals and Physicians

Attachment



MCV Campus

V i r g i n i a C o m m o n w e a l t h U n i v e r s i t y

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November 12, 2002

Patrick W. Finnerty, Director
Department of Medical Assistance Services
600 East Broad Street
Richmond, Va. 23219

Dear Mr. Finnerty:

Thank you for providing us with the opportunity to review and comment on the draft report written by the U.S. Department of Health and Human Services Office of the Inspector General (OIG) entitled "Review of Medicaid Disproportionate Share Hospital Payments Made by Virginia's Department of Medical Assistance Services to the Medical College of Virginia Hospitals for the Fiscal Years ending June 30, 1997 and June 30, 1998" (hereinafter the "Draft Report"). We request that our comments to you be passed along to the OIG as part of your formal response to the report.

In summary, we respectfully disagree with many of the conclusions reached in the Draft Report. The OIG's Draft Report misinterprets the Medicaid statute and the flexibility granted to states with regard to the limit mandated by Section 13621 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) on disproportionate share hospital (DSH) payments. In particular, we continue to believe that costs incurred by the Medical College of Virginia Hospitals (MCVH) for physician services were properly included in our hospital-specific DSH cap. With respect to the methodology for calculating uncompensated care costs, while we believe our original methodology was permissible, we have revised our methodology according to the Draft Report's guidelines. Doing so, however, results in higher uncompensated costs than we had originally estimated. We therefore disagree with the Draft Report's conclusion that MCVH was overpaid for its uncompensated costs in state fiscal years (SFYs) 1997 and 1998. We also believe that the OIG should remove discussion of both federal disallowances, since they have been resolved in Virginia's favor, and of costs relating to prisoners, since the Centers for Medicare and Medicaid Services has provided prospective guidance on this issue.

Once again, we thank you for allowing this opportunity to comment on the OIG Draft Report. We look forward to working with you in the future on efforts to provide quality health care to Virginia's low-income residents.

Sincerely,

Dr. Hermes A. Kontos
Chief Executive Officer

Dominic J. Puleo
Chief Financial Officer

VCU Health System Authority

**Response to the Department of Health and Human Services
Office of the Inspector General's
"Review of Medicaid Disproportionate Share Hospital Payments made
by Virginia's Department of Medical Assistance Services to the Medical
College of Virginia Hospitals for the Fiscal Years Ending June 30, 1997
and June 30, 1998
A-03-01-00222"**

November 13, 2002

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This portion of VCU's response has been deleted as it pertained to matters included in the draft report which are no longer contained in the final report.

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**VCU Health System Authority
Response to the Department of Health and Human Services
Office of the Inspector General's
"Review of Medicaid Disproportionate Share Hospital Payments made by Virginia's
Department of Medical Assistance Services to the Medical College of Virginia
Hospitals for the Fiscal Years Ending June 30, 1997 and June 30, 1998
A-03-01-00222"**

After site audits of the Virginia Commonwealth University (VCU) Health System Authority¹ in the spring and summer of 2001, the Department of Health and Human Services Office of the Inspector General (OIG) issued its draft report in August 2002, entitled "Review of Medicaid Disproportionate Share Hospital Payments made by Virginia's Department of Medical Assistance Services to the Medical College of Virginia Hospitals for the Fiscal Years Ending June 30, 1997 and June 30, 1998 A-03-01-00222" (hereinafter the "Draft Report"). This document provides VCU Health System's response to that Draft Report.

As set forth more fully below, we respectfully disagree with many of the conclusions reached in the Draft Report. We do so because our analysis reflects that the OIG's Draft Report misinterprets the Medicaid statute and the flexibility granted to states with regard to the limit mandated by Section 13621 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) on disproportionate share hospital (DSH) payments. This limit is known as the OBRA 1993 cap or the hospital-specific DSH cap. In particular, we continue to believe that costs incurred by MCVH for physician services were properly included in our hospital-specific DSH cap. Additionally, with respect to the methodology for calculating uncompensated care costs, while we believe our original methodology was permissible, we have revised our methodology according to the Draft Report's guidelines. Doing so, however, results in higher uncompensated costs than MCVH had originally estimated. We therefore disagree with the Draft Report's conclusion that MCVH was overpaid for its uncompensated costs in state fiscal years (SFYs) 1997 and 1998.

Summary

The OIG asserts two stated objectives in its review of the hospital-specific DSH cap with regard to payments to the Medical College of Virginia Hospitals (MCVH), which is now operated by the Virginia Commonwealth University (VCU) Health System Authority. The OIG intends "to determine if DSH payments to MCVH for SFYs 1997 and 1998 (1) were calculated in accordance with the approved State plan and (2) did not exceed the uncompensated care costs (UCC) as mandated by OBRA 1993." Draft Report at i, 2. The OIG states in its draft report that "DSH payments were calculated in accordance with

¹ As described further below, the VCU Health System Authority now operates the Medical College of Virginia Hospitals (MCVH) which was the subject of the OIG review.

the State plan” *Id.* at i, 3, and limits comments to its second objective of determining whether payments exceeded the hospital-specific DSH caps.

The OIG claims to have found two major deficiencies in the calculation of UCC by MCVH in SFYs 1997 and 1998. First, in a section entitled “Overstated UCC,” the OIG “found that MCVH overstated its UCC by including costs that did not meet Federal guidelines.” *id.* at 3. This finding is based entirely on MCVH’s inclusion of physician costs incurred by the MCVH under agreement with MCV Physicians -- a related physician practice plan that is also part of the VCU Health System Authority -- to provide the physician component of hospital services to indigent patients of MCVH. The OIG claims that costs incurred by MCVH for services provided by MCV Physicians were not MCVH’s costs and thus were not includable in UCC used for DSH. The OIG also asserts that these costs are unallowable under Medicare principles of cost reimbursement.

The OIG’s finding with respect to the cost of physician services is incorrect for a number of reasons. First, MCVH incurred substantial and necessary costs for the provision of the physician component of hospital services to indigent patients. Those costs are reimbursable under Medicare principles of cost reimbursement and also fit within the statutory description of the hospital-specific DSH cap and administrative guidance provided by the federal Centers for Medicare and Medicaid Services (CMS). In addition, to the extent that physician costs incurred by hospitals are not specifically mentioned in either the statute or guidance, CMS’s predecessor the Health Care Financing Administration (HCFA)² granted broad flexibility to states in terms of defining costs includable in the hospital-specific DSH cap, and the states have sufficient flexibility to include physician costs as a component of hospital services.

The second major deficiency that the OIG claims to have found, referred to in the Draft Report as “Unresolved UCC,” relates to UCC of over \$90 million in 1997 and over \$80 million in 1998, on which the OIG was “unable to render an opinion.” The OIG takes issue with MCVH’s UCC calculations within two broad categories, Indigent Care Costs and Bad Debt Costs. For each of these categories, the OIG claims that MCVH’s calculation of UCC (1) improperly included the costs of insured persons, (2) improperly included costs related to services provided in prior years, and, (3) in the case of Bad Debt Costs only, did not offset payments against bad debts.

With regard to the “Unresolved UCC,” we believe that MCVH’s UCC calculations were reasonable estimates of uncompensated costs incurred by the hospital for treating patients without insurance. MCVH adjusted the costs in each category to exclude costs associated with insured persons. And while MCVH did include costs of services provided in prior years, MCVH did so because it could not verify their indigent status until the year the costs were claimed. These costs were more than offset, however, by costs that were *excluded* for services provided in the year in question to patients whose indigent status had not yet been verified. We recognize that in the original estimates, MCVH did not offset our bad debt costs by payments received. As is the case with physician costs,

² For ease of reference, throughout the remainder of this letter, actions by either CMS or CMS’s predecessor HCFA are referred to as though they were actions by CMS.

MCVH's approach to calculating UCC, accepted by Virginia, was particularly reasonable given the broad flexibility explicitly granted to states in interpreting the hospital-specific DSH cap.

Nevertheless, we are willing to acknowledge for the purposes of this document that the OIG's interpretations are also reasonable (though not mandated) and have recalculated MCVH's UCC using the strict interpretations demanded by the OIG. Since our recalculated UCC actually results in higher estimates of the uncompensated care costs incurred by MCVH to provide care to Medicaid and uninsured patients, our calculations confirm that no overpayment was made to MCVH in SFYs 1997 or 1998.

We also comment below with regard to two additional matters contained in the OIG's Draft Report. First, the OIG notes that CMS had disallowed federal financial participation (FFP) for certain DSH claims made by the Virginia Department of Medical Assistance Services (DMAS). Given the fact that these matters have been resolved in DMAS's favor, the OIG should remove any reference to this disallowance in its report. Second, the OIG notes in its draft report that MCVH had included in its UCC calculation the costs of providing hospital services to prisoners of the Virginia Department of Corrections. The OIG acknowledges that CMS, at the time of the writing of the Draft Report, had "not issued statewide (sic) guidance on this issue." Because CMS has recently issued prospective guidance to states, we similarly recommend that this issue be removed from the OIG's report on SFYs 1997 and 1998.

DSH Background

Congress first required that states provide rates that "take into account the situation of hospitals which serve a disproportionate share of low income patients" in the Omnibus Budget Reconciliation Act of 1981.³ As detailed in the legislative history, the purpose of this provision was to ensure that States and the federal government provide critically needed supplemental funds to safety net hospitals, recognizing:

[s]uch hospitals, especially in urban areas, are often multi-faceted health care institutions, which provide many health and social services to all residents of their area, in addition to serving as hospitals of last resort for the poor. Their sizeable Medicaid populations often require extra social and public health services. In addition, in many areas such hospitals also provide considerable care for indigent persons not eligible for Medicaid, who often have only partial or no health care coverage.⁴

In the decade following enactment of the original DSH requirements, Congress amended the statute to mandate increased State implementation of DSH programs,⁵ while also preserving considerable flexibility for States to craft DSH programs that match the

³ Pub. L. No. 97-35, 95 Stat. 808, § 2173(B)(ii).

⁴ H.R. Rep. 97-158, at 295 (1981) (Budget Committee Report discussing provision eventually incorporated in Pub. L. No. 97-35).

⁵ Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, 101 Stat. 1330, § 4112.

particular needs of their own disproportionate share hospitals.⁶ Congress explicitly recognized that supplemental DSH funds were necessary in order to ensure the viability of the facilities relied on by Medicaid-eligible and uninsured patients:

These "disproportionate share" hospitals are an essential element of the Nation's health care delivery system, and the Federal and State governments, through the Medicaid program, have an obligation to assure that payment levels assist these facilities in surviving the financial consequences of competition in the health care marketplace.⁷

In 1991 and 1993, Congress began placing some limits on state DSH programs.⁸ In particular, in 1993 Congress created the hospital-specific DSH cap, which limits DSH payments to a hospital to

the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of [Medicaid] payments ... and by uninsured patients) by the hospital to individuals who either are eligible for [Medicaid] or have no insurance (or other source of third party coverage) for services provided during the year.⁹

In the nine years since adoption of the OBRA 93 cap, CMS has provided very little guidance with regard to how it should be interpreted and implemented by states and nothing with the force and effect of law. In 1994, CMS issued an interpretive letter to State Medicaid Directors on the topic. In that letter, CMS emphasized the significant state flexibility in interpreting the requirements on the new limit. In particular, with regard to what costs may be included in calculating the hospital-specific DSH cap, CMS stated specifically that CMS would "permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined ... do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement."¹⁰ Subsequent to that letter there has been only one additional letter to State Medicaid Directors with regard to the hospital-specific DSH cap, and that letter was issued August 16, 2002. Although this recent letter did clarify issues in a number of areas (including inclusion of the costs of serving prisoners), the letter in no way detracted from the broad flexibility granted states in the 1994 letter. It also did not provide any guidance with respect to the specific issues raised by the OIG in its draft report. In addition to the two formal letters to State Medicaid Directors, an additional possible source of interpretation with regard to the hospital-specific DSH cap is a January 10, 1995 letter from the Medicaid Bureau Director to the Chair of the State Medicaid Director's Association. Although a private letter, this letter has occasionally been cited as justification for CMS positions.

⁶ See, e.g., Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388, § 4703 (regarding state flexibility in designing payment methodologies).

⁷ H.R. Rep. 100-391(I) at 524 (1987).

⁸ Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. No. 102-234, 105 Stat. 1793; Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312, § 13621.

⁹ 42 U.S.C. § 1396r-4(g)(1)(A).

¹⁰ Letter from Sally K. Richardson to State Medicaid Directors (Aug. 17, 1994) at 3 (emphasis added).

MCVH Background

MCVH, which is now operated by the VCU Health System Authority, is precisely the type of institution that DSH payments were designed to support. For many decades, MCVH has provided and continues to provide health care services in an inner-city location to large numbers of low-income patients who are without health insurance or who have Medicaid benefits that do not fully compensate for the services provided.¹¹ The VCU Health System Authority had over 15,000 Medicaid and self pay (uninsured) discharges and over 160,000 Medicaid and self-pay outpatient visits in both 1997 and 1998. Over 25 percent of its inpatient population and over 34 percent of its outpatient population had no insurance.¹² MCVH is now, and has traditionally been, the largest hospital provider of care to uninsured patients in Virginia.

MCVH has a rich tradition of providing services to low-income patients, with a history dating back to 1838. In 1965, the Virginia Commonwealth University was created from a merger of the Medical College of Virginia and another institution of higher learning, with MCVH operated as part of the health sciences division of VCU. On July 1, 1997, operation of MCVH was transferred from VCU to a new health care authority, the MCV Hospitals Authority.¹³ Among the goals of this reorganization was to provide MCVH with greater flexibility than it could exercise as a part of the State university system in the areas of capital improvements, alliances with other health care providers, and personnel matters. MCVH's need for flexibility was heavily influenced by the financial burdens of providing indigent care, estimated in 1997 as totaling approximately \$108 million, with only about \$80 million reimbursed by the government.

The burden of providing uncompensated care to indigent patients is much greater for physicians providing services at high disproportionate share hospitals such as MCVH than at other community hospitals. Many hospitals, especially safety net hospitals, directly employ their physicians in order to assure equal access to physician services for both paying patients and non-paying patients. The costs of these physician salaries are part of the hospital's overall costs of care. Others, like MCVH, contract for physician services, and provide contractual payments for the substantial volumes of indigent care that the physicians are expected to provide. In many cases, without such contractual payments, the hospitals simply would not be able to secure the necessary physician coverage for their indigent patient population. Physician services are obviously a key

¹¹ This mission of providing health care to the urban poor is so firmly entrenched that when the Virginia legislature created the VCU Health System Authority, it reaffirmed provision of medical care to indigent patients as one of the missions of MCVH and required the Authority to continue to provide indigent care services on the Medical College of Virginia campus, including in Richmond. See VA. Code Ann. §§ 23-50.16:2(4), 23-50.16:17 (1996).

¹² National Association of Public Hospitals and Health Systems, *America's Safety Net Hospitals and Health Systems, 1997: Results of the 1997 Annual NAPH Member Survey*, Tables 3 and 4 (1999); National Association of Public Hospitals and Health Systems, *America's Safety Net Hospitals and Health Systems, 1998: Results of the 1998 Annual NAPH Member Survey*, Tables 3 and 4 (2000).

¹³ On July 1, 2000, subsequent to the period at issue in the OIG audit, the name of the MCV Hospitals Authority was changed to the Virginia Commonwealth University Health System Authority, its board was expanded to include five faculty physicians (*i.e.*, members of MCV Physicians), see VA. Code Ann. §23-50.16:5 (2000), and the Authority board was granted appointive control of the MCV Physicians board.

component of the hospital's ability to provide health services to its patients. Therefore, the costs of these contractual payments for physician services for indigent care, like physician salaries for hospitals employing physicians, are an integral cost of providing hospital services to these patients.

In an academic health center, it is most common for faculty physicians, such as those staffing MCVH, to function through a faculty practice plan. That is, the physicians may set up a practice plan as a separate legal entity through which they bill third party payers for their services. The academic hospital or its affiliated medical school will then pay the practice plan for their services instead of directly compensating the physicians. The practical effect is the same, whether the physicians are employed directly by the hospital, or through a practice plan: the physicians provide care to the hospital's uninsured patients, and the hospital provides compensation for these services.

VCU's faculty physicians have long functioned through a faculty practice plan. Since the mid-1990s, MCV Physicians has served as the unified practice plan. The plan is an entity distinct from VCU and MCVH, but has remained very closely affiliated with each, providing physician services to MCVH since its inception.

By SFY 1998, this close relationship took the form of a contract and subcontract, whereby these faculty physicians were engaged to provide services at MCVH, including services to the indigent and uninsured. MCVH agreed to compensate these services at (or below) MCV Physicians' actual cost of providing them. Specifically, for SFY 1998 the MCV Hospitals Authority contracted with VCU, and VCU subcontracted with MCV Physicians, for provision of physician services; MCV Physicians passed its costs through without markup to VCU, and VCU did the same regarding its charges to the MCV Hospitals Authority.¹⁴ (Indeed, MCVH's payments were discounted to reflect the fact that it was reimbursed at less than cost for services to the indigent. Further illustrating the close affiliation among these entities, MCV Physicians absorbed its pro rata "share" of this underpayment.) The contract includes a justification of need:

The Authority mission includes the provision of necessary medical and dental services to indigent patients. This mission can not be fulfilled without professional services provided by qualified physicians, dentists and other licensed healthcare providers.

A similar arrangement existed for SFY 1997 but was not memorialized in a contractual agreement, in part because MCVH was still operating as part of the University, and VCU did not have a need to recognize by contract the transfer of funds between one part of the University and the University's physicians.

The approved Medicaid State Plan in effect during SFY 1997 and 1998 authorizes MCVH to receive DSH payments up to the limit provided by federal law. As noted in the OIG's Draft Report, the State Plan in 1997 provided as follows:

¹⁴ See Exhibit C of the Contract between the Virginia Commonwealth University Health System Authority and VCU. This exhibit is attached to this letter as Exhibit 1.

No [DSH] payments ... shall exceed any applicable limitations upon such payments established by federal law or regulations and OBRA 1993 § 13621. A payment adjustment during a fiscal year shall not exceed the sum of:

- (a) Medicaid allowable costs incurred during the year less Medicaid payments, net of disproportionate share payment adjustments, for services provided during the year, and
- (b) Costs incurred in serving persons who have no insurance less payments received from those patients or from a third party on behalf of those patients....¹⁵

It is not disputed that DMAS accepted MCVH's hospital costs of providing indigent health services – including the costs of its contract physicians – as allowable hospital costs under this State Plan for the purposes of calculating MCVH's hospital specific DSH cap.

I. Costs incurred by MCVH for the physician component of its hospital services were properly included in MCVH's calculation of its hospital-specific DSH cap.

The OIG Draft Report contends that MCVH overstated its UCC in calculating its hospital-specific DSH cap based on two allegations. First, the OIG alleges that the costs included by MCVH “represented estimated costs incurred by MCV Physicians for treating indigent patients” and “not MCVH's costs incurred for furnishing hospital services” because “MCV Physicians and MCVH were separate legal entities during SFYs 1997 and 1998.” Draft Report at 5. In addition, the OIG alleges that these costs are unallowable under Medicare principles of cost reimbursement. *Id.* As explained below, these allegations are groundless, based on the relationship between MCVH and MCV Physicians, the Medicare program's implementation of its reimbursement principles, Medicaid statutes and regulations, and the deference due Virginia's interpretation of its State Medicaid Plan.

A. MCVH incurred actual costs of providing the physician component of hospital services to indigent patients.

The Draft Report is factually wrong in asserting that the cost of physician services provided to indigent patients at MCVH during the years addressed in the report was not MCVH's cost. As part of MCVH's commitment to providing hospital services to indigent patients, MCV Physicians has provided the professional component of such services and been paid by MCVH for these services.

Beginning in SFY 1998, after the authority was established, MCVH entered into a formal contract with VCU to provide such hospital services to indigent patients and to obtain professional services from VCU. VCU provided those services through a subcontract

¹⁵ Virginia Medicaid State Plan, Attachment 4.19-A, page 5 of 28, TN No. 96-02.

with MCV Physicians.¹⁶ In both SFYs 1997 and 1998, the hospital incurred costs for these professional services, rendering them hospital costs of providing care to indigent patients. It is simply not true to claim that the hospital did not incur costs for physician services.

The OIG appears to contend that the fact that MCV Physicians and MCVH were separate entities somehow supports its conclusion. MCVH is claiming the *contractual* costs of providing physician services – costs that the hospital has incurred. It is not directly claiming costs that an unrelated entity has incurred and which the hospital has not reimbursed. In this case, MCVH's contractual costs are a portion of MCV Physicians' unreimbursed costs of indigent care. MCVH did not include in its UCC any costs incurred by MCV Physicians that were not reimbursed through the contract. In short, the OIG misunderstands the nature of MCVH's uncompensated physician costs, assuming them to be costs incurred by an unrelated entity rather than costs directly assumed via contract by the hospital.¹⁷

B. Medicare principles of cost reimbursement permit hospitals like MCVH to receive reimbursement for the physician component of hospital services.

In its 1994 letter to State Medicaid Directors, CMS set “the amounts that would be allowable under the Medicare principles of cost reimbursement” as a limit on costs permitted in calculating the hospital-specific DSH cap.¹⁸ Medicare principles of cost reimbursement are set forth in the Medicare statute¹⁹ and regulations,²⁰ which are interpreted in the Medicare Manuals that instruct CMS's Fiscal Intermediaries and Carriers. These sources include long-standing and wide-reaching Medicare provisions that explicitly permit hospitals to be reimbursed for the expenses hospitals incur for certain physician services.

For example, teaching hospitals may elect to receive reimbursement on a reasonable cost basis for the hospital costs of providing physician services in the hospital. In order to seek reimbursement for teaching physician costs as hospital costs, the physicians must agree not to bill separately for services provided to Medicare beneficiaries, or they must all be hospital employees, precluded from billing separately as a condition of

¹⁶ See Exhibit C of the Contract between the Virginia Commonwealth University Health System Authority and VCU (attached to this document as Exhibit 1).

¹⁷ Significant arguments also exist for the inclusion of physician costs under Medicare's “related organization” principle due to the significant commonality of control between MCVH and MCV Physicians, particularly in 1997 and 1998. See 42 C.F.R. § 413.17. Even the OIG describes MCV Physicians as being “related” to MCVH. See Draft Report at i (“Unallowable costs consisted of costs of a related entity.”).

¹⁸ Letter from Sally K. Richardson to State Medicaid Directors at 3 (emphasis added). MCVH does not concede that this letter, which did not go through formal notice or comment rulemaking process, is binding on states, though we accept for purposes of this argument the very general guidance provided therein.

¹⁹ See 42 U.S.C. §§ 1395f(b), 1395x(v)(1)(A) (“The reasonable cost of any services shall be the cost *actually incurred* ... in the efficient delivery of needed health services”) (emphasis added).

²⁰ See 42 C.F.R. § 413.5 (“All necessary and proper expenses of an institution in the production of services ... are recognized.”).

employment.²¹ Other hospitals that choose to charge patients according to an “all-inclusive rate” may be reimbursed for their Medicare expenses on a per diem basis. The all-inclusive rate is “computed (for inpatients) on a daily or other time basis, or (for outpatients) on a per-visit basis applicable uniformly to each patient *without regard [to] the distinction between physicians’ and hospital services.*”²² The per diem reimbursement to all-inclusive rate hospitals includes the costs of compensating only those hospital-based physicians “who normally render services to Medicare beneficiaries.”²³ Medicare principles of cost reimbursement similarly permit hospitals to seek reimbursement for certain expenses they have incurred in providing the following types of physician services: supervisory physicians in teaching hospitals, emergency room physicians, End Stage Renal Disease physicians and anesthetists.²⁴ Medicare also recognizes contractual costs assumed by a hospital “for the purpose of having services furnished for or on behalf of it” if the contractual payments are not based on a percentage of charges, revenues or reimbursement.²⁵

In a recent report on California’s compliance with the hospital-specific DSH cap in relation to Kern Medical Center, the OIG specifically included costs associated with professional services provided by hospital-based physicians in the hospital’s UCC. The report states that “[a]lthough professional medical services costs were not included in the reimbursement cost category of KMC’s Medicare Cost Report, they may be reimbursed as physician services under the Medicare Part B program, per section 1887(a)(1)(A) of the [Social Security] Act.”²⁶ The OIG has thus already acknowledged that under Medicare principles of cost reimbursement, the costs incurred in providing hospital services may properly include the hospital’s costs for physician professional services rendered to hospital patients. There is no reason why the OIG should include Kern’s physician costs and exclude MCVH’s.

In any case, the extent to which Medicare recognizes a hospital’s contractual costs of obtaining physician coverage for *Medicare* patients is only marginally relevant in the indigent care context. The Medicare hospital reimbursement system is based on the reality that most physicians providing services in a hospital would prefer to bill separately for their services under Part B. Medicare has therefore adopted a set of rules to ensure that hospitals are not reimbursed for the costs associated with physicians who have already been reimbursed through Part B. For indigent care, however, there is no Part B payer and thus no possibility of double dipping. To the extent, therefore, that

²¹ Carrier Manual (CAR)3 8201.B1; CAR3 15016.C.

²² CAR3 8300.1F (emphasis added).

²³ CAR3 8099, Exhibit 7.

²⁴ See, e.g., CAR3 8201.B1, CAR3 15016.C (permitting reimbursement for physician services in teaching hospitals as hospital costs); Provider Reimbursement Manual – End Stage Renal Disease (PRM ESRD) 2715.1 (permitting reimbursement for dialysis-related physician services as hospital costs); CAR3 8020.1 (permitting reimbursement for some emergency room physician services as hospital costs); CAR3 8308.1A, CAR3 16003.G (permitting reimbursement for the services of certain nurse anesthetists in rural hospitals as hospital costs).

²⁵ 42 U.S.C. § 1395xx(b)(1).

²⁶ Office of the Inspector General, Audit of California’s Medicaid Inpatient Disproportionate Share Hospital Payment for Kern Medical Center, Bakersfield, California, State Fiscal Year 1998, A-09-01-00098, page 7 (September 24, 2002).

hospitals incur actual unreimbursed costs associated with providing physician coverage for indigent care, those costs should be included in the hospital's UCC for purposes of Medicaid DSH. Medicare reasonable cost principles are relevant only as applied to situations in the Medicare context where the hospital and not the physician is being reimbursed for the professional services provided. It is in these situations, spelled out in detail above, that Medicare has established a process for determining the extent of a hospital's reasonable costs. Because Medicare does recognize hospital costs for physician services, those principles should be applied to permit MCVH to include its unreimbursed costs of physicians services in its UCC.

C. The Medicaid DSH statute permits a definition of hospital services that includes necessary physician components.

Aside from claiming that MCVH did not incur the costs for the physician component of the hospital services provided by MCV Physicians (which is not accurate) and claiming that these costs are not allowable under the Medicare principles of cost reimbursement (which is also not accurate), the Draft Report suggests that the cost of physician services are not reimbursable through DSH because they are not "hospital services." The OIG stresses the statutory language limiting DSH payments to the unreimbursed "costs incurred during the year of furnishing hospital services."²⁷ The OIG's implied definition of "hospital services" is unsupported by statute, regulations or other agency action and is contrary to congressional intent in establishing the DSH program.

First, CMS has preserved great flexibility for States to interpret the calculation of the allowable costs in the hospital-specific DSH cap. Specifically, CMS has interpreted the legislation to mean that a State may "use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement."²⁸

Second, the regulatory definition of hospital services in Medicaid regulations is quite broad and can easily include physician services. (The Medicaid statute itself includes no elaborate definition of "hospital services," "inpatient hospital services," or "outpatient hospital services."²⁹) According to the Medicaid regulations, "inpatient hospital services" are services that

- (1) are ordinarily furnished in a hospital for the care and treatment of inpatients;
- (2) are furnished under the direction of a physician or dentist; and
- (3) are furnished in an institution that –
 - (i) is maintained primarily for the care and treatment of patients with disorders other than mental diseases;
 - (ii) is licensed or formally approved as a hospital ...
 - (iii) meets the requirements for participation in Medicare as a hospital; and

²⁷ 42 U.S.C. § 1396r-4(g); see Draft Report at 4-5.

²⁸ Letter from Sally K. Richardson to State Medicaid Directors (Aug. 17, 1994) at 3.

²⁹ See 42 U.S.C. § 1396d.

(iv) has in effect a utilization review plan³⁰

“Outpatient hospital services” are similarly defined.³¹

Services provided by physicians in an inpatient or outpatient hospital setting may clearly be included in these definitions. Although physicians’ services are separately defined in the Medicaid regulations,³² a separate regulatory definition for physicians’ services in no way suggests that services satisfying that definition may not also qualify as hospital services. For example, laboratory, and x-ray services,³³ as well as diagnostic, screening, preventive and rehabilitative services,³⁴ prescription drugs³⁵ are all separately defined in the Medicaid regulations, yet each may be reimbursed as hospital services when provided in a hospital setting. The costs incurred by the hospital in providing each of these types of services are typically included in the calculation of a hospital’s uncompensated costs, and the OIG did not dispute MCVH’s inclusion of such costs in its UCC determination. The OIG provides no legal explanation for its differential treatment of physician services.

Furthermore, the Draft Report’s implied narrow definition of hospital services would defeat the purposes of the DSH statute. The DSH statute was enacted to ensure that low-income patients had access to services provided by hospitals serving a disproportionate share of Medicaid and uninsured patients. When such hospitals are required to provide subsidies to physicians to ensure adequate physician coverage for their low-income patients, the subsidy costs are part and parcel of the costs of providing “hospital services.” Without physicians, there will be no services for the hospital to provide. By ignoring the very real costs incurred by hospitals in providing the professional component of hospital services, the OIG’s tortured definition of “hospital services” defeats the purpose of the DSH statute.

Because the OIG interpretation of allowable costs under the hospital-specific DSH cap is not compelled by statute, regulations or policy guidance, it should be disregarded.

D. CMS and the OIG should defer to Virginia’s proper determination that MCVH’s costs of providing professional services to indigent patients are hospital costs.

States’ interpretation of their own state plans are entitled to federal deference.³⁶ As demonstrated above, the federal definitions of inpatient and outpatient hospital services are broad enough to include physician services. And the federal guidance on calculating

³⁰ 42 C.F.R. § 440.10(a).

³¹ 42 C.F.R. § 440.20(a). In fact, outpatient hospital services even more clearly can include physician services, since these services must be “furnished by or under the direction of a physician or dentist.” *Id.* (emphasis added).

³² 42 C.F.R. § 440.50.

³³ 42 C.F.R. § 440.30.

³⁴ 42 C.F.R. § 440.130.

³⁵ 42 C.F.R. § 440.120.

³⁶ See, e.g., Department of Health and Human Services Departmental Appeals Board Decision No. 1836 (Aug. 2, 2002) at 2 (holding that “Virginia’s interpretation of its own state plan is entitled to deference” in calculating and making enhanced DSH payments).

DSH caps allows for broad flexibility as long as costs do not exceed those using Medicare reimbursement principles.³⁷ Virginia has determined that, under its state plan, the definition of the costs of hospital services includes costs incurred by the hospital to obtain physician services that are a necessary component of hospital care. Virginia has also determined that, under its state plan, DSH payments may be made for such costs. The OIG and CMS should defer to Virginia's reasonable interpretation of its state plan because the interpretation does not contradict any explicit federal statutory, regulatory or other administrative guidance in this area.

II. MCVH's method of calculating costs incurred for uninsured and Medicaid patients is an acceptable method; however, even using the OIG's recommended methodology, MCVH was not overpaid for its UCC.

In SFYs 1997 and 1998, MCVH derived the bulk of its UCC for uninsured patients from the costs associated with two categories of patients, indigent care patients and bad debt patients. The first category of patients included all of those patients who meet the Commonwealth of Virginia's indigent care criteria (which include both insured and uninsured patients).³⁸ The second category consisted of patients, primarily but not exclusively self-pay patients, for whom full payment was not received. Because neither of these categories is exclusively comprised of uninsured patients, MCVH determined costs applicable to DSH by including only the percentage of the costs attributable to uninsured individuals.

The OIG's Draft Report raises a number of concerns about the methodology used for both of these categories. First, the OIG complains that MCVH included costs in both of these categories for some patients with insurance. Second, the OIG objects to the inclusion of patients that received care in a prior year but were determined to be indigent during the SFY at issue. Finally, with regard to bad debts, the OIG asserts that MCVH improperly failed to offset its costs by payments received.

MCVH's UCC calculations were reasonable estimates of uncompensated costs incurred by the hospital for treating patients without insurance. CMS has made it clear that there is not one single methodology for estimating UCC costs and has granted states broad flexibility in this arena. We therefore believe it is inappropriate for the OIG to insist that its methodology – which, for the purposes of this document, we are willing to concede is reasonable – is the only acceptable approach to calculating the DSH cap. MCVH's specific responses to each of the three categories of OIG concerns are detailed below.

Sections A through C below respond to the OIG's specific complaints and provide MCVH's specific responses. However, because we are willing to concede for the purposes of this document that the OIG's interpretations are also reasonable, in section D below we describe our recalculation of MCVH's UCC in 1997 and 1998 using the interpretations demanded by the OIG. Our recalculations of UCC actually result in

³⁷ See Letter from Sally K. Richardson to State Medicaid Directors (Aug. 17, 1994) at 3.

³⁸ See Va. Code Ann. § 32.1-333 C.1.

higher, not lower, estimates of UCC, and thus confirm that no overpayment was made to MCVH in SFYs 1997 or 1998, even using the OIG's interpretations.

Attached to this document are two exhibits, Exhibits 2 and 3, which describe MCVH's UCC calculation for SFYs 1997 and 1998, respectively. Each exhibit provides three versions of calculations to determine UCC. The first column (labeled "updated 2/12/01") represents the initial methodology for determining the hospital-specific DSH cap shared with the OIG auditor and the second column (labeled "updated 5/31/01") represents changes made explicitly at the OIG auditor's request when on-site. Both of these columns were shared with the OIG auditor. Numbers in the first column match numbers in the OIG Draft Report. See Draft Report, App. A. The third column (labeled "updated 11/1/02") represents our current efforts to provide a calculation that complies with the OIG's recommended methodology as contained in the Draft Report.

A. MCVH adjusted its estimates of uncompensated costs of indigent care and bad debt statistically and conservatively to ensure that it did not include costs for patients with insurance.

With regard to both indigent care costs and bad debt costs, the OIG asserts that MCVH included costs for patients with health insurance. MCVH does not deny that the categories of patient accounts classified as indigent or bad debt did indeed contain some patients with insurance. However, MCVH did not include the costs of care for all patients in either of these categories in the calculation of the hospital-specific DSH cap, but rather statistically reduced the category-wide costs to account for the insured patients. The OIG auditor was made fully aware of this approach during site visits to MCVH.

When the OIG conducted its investigation, MCVH had calculated its UCC for uninsured individuals based on the percentage of the total costs for patients in the indigent care and bad debt categories that were attributable to uninsured individuals. For example, in the first column of Exhibit 2 for 1997, MCVH listed \$61.6 million in total inpatient indigent care costs and \$28.1 million in total outpatient indigent care costs. These costs are total costs for all patients classified as indigent, whether they have insurance or not. MCVH then reduced these total costs by a percentage reflecting the portion of patients in each category that were uninsured.

The OIG auditor initially questioned the derivation of the percentages that MCVH applied to adjust the indigent care and bad debt costs. In order to respond to the OIG's concerns, MCVH examined the full population contained in the indigent care and bad debt categories to obtain the precise percentage of uninsured individuals in those categories. In other words, we developed a percentage of uninsured individuals in each category by determining the ratio of charges associated with insured individuals to total charges. The percentage was based on an analysis of every account in the category, not a sample or subset. In every category, the recalculation requested by the OIG resulted in higher estimates of the unreimbursed cost of serving MCVH's uninsured patient population than our original estimates. In looking at the full population of the indigent care category for each of the years, MCVH found that 96.6 percent of inpatient indigent care revenues in 1997 and 97.8 percent in 1998 were attributable to the uninsured. On

the outpatient side, 96.4 percent of outpatient indigent care revenues in 1997 and 97.3 percent in 1998 were attributable to the uninsured. For the bad debt categories, 88.97 percent of the bad debt category revenues in 1997 were for the uninsured and 84.67 percent were for the uninsured in 1998.

In order to make sure that MCVH did not include costs attributable to insured patients, MCVH reduced the total costs attributable to the indigent care and bad debt categories by the above percentages. For example, total inpatient indigent care costs in 1997 were \$61.6 million. However, because only 96.6 percent of inpatient indigent care was attributable to uninsured persons, MCVH included only 96.6 percent of the \$61.6 million (\$59.5 million) as UCC includable in DSH. These revised percentages were used to create the calculations in the second column of Exhibits 2 and 3. These revised calculations (which in fact resulted in a higher estimate of the total uninsured unreimbursed costs) were shared with the OIG auditor in May 2001.

In the course of its audit, the OIG sampled patient accounts included in both the indigent and bad debt categories to determine whether they included accounts for patients with insurance. The sampling was not done statistically (as admitted in the Draft Report), but rather taken of those accounts most likely to include insured patients. The auditor found insured patients in both of the samples. We are not surprised by this result, since the presence of insured patients in the pool was the very purpose of our statistical corrections. The OIG's investigation is startlingly out of line with MCVH's methodology. Rather than conduct statistically valid sampling in order to verify MCVH's methodology for statistically correcting the calculation of uninsured costs, the OIG took "non-statistical samples"³⁹ in order to verify what MCVH already knew.

It is MCVH's primary position that, for reasons stated above, MCVH's methodology for estimating the costs of providing care to the uninsured populations is valid. Through statistical correction, MCVH assured that the costs derived from the indigent care and bad debt categories truly reflected the costs incurred treating the uninsured and no more. Given CMS's explicit grant of broad discretion to the states in calculating allowable costs under the hospital-specific DSH cap,⁴⁰ the methodology used by MCVH was (and is) an entirely reasonable one.

B. MCVH's indigent care and bad debt categories included patients with dates of service in prior years.

The OIG also objects to the inclusion of costs associated with the indigent care and bad debt provided in prior years. MCVH acknowledges that it included such prior year costs. We point out, however, that MCVH *excluded* current year costs for patients whose bad debt or indigent status has not yet been determined. We believe that in waiting until the indigent or bad debt nature of these accounts was verified rather than including them in the year the costs were incurred, our approach is more conservative than that advocated by the OIG.

³⁹ Draft Report at 6, 8.

⁴⁰ See *supra*.

The OIG nevertheless argues that the DSH statute permits only payments for "costs incurred during the year of furnishing hospital services"⁴¹ It supports its literal interpretation of this language by reference to a private letter from January 1995 to the State Medicaid Director's Association, in which CMS expresses its view that states should "match costs for hospital services provided during a particular year to payment received relating to those services provided for a particular year."⁴² That letter, however, goes on to explain that states need not continually recalculate these costs based on payments subsequently received for costs incurred during the year. Rather, "for the purpose of matching uninsured services costs for a particular year to revenue receipts relating to uninsured services for a particular year, it would be appropriate for the State to estimate the amount it expects to collect for uninsured services for a particular year." CMS then emphasizes state flexibility in developing methods and standards for estimating these payments, and clarifies that states may either estimate actual payments received or make retroactive settlements based on actual payments received.⁴³

MCVH routinely provides services to patients whose eligibility under the Commonwealth's indigent care criteria has not been determined or for whom it expects third-party or self-pay reimbursement. Often it is several months or even years before the indigent status is finally determined or the charges are written off as bad debt. Under MCVH's methodology, it waited until indigent or bad debt status was verified before including the costs in UCC and claiming DSH reimbursement. In thus deferring DSH claiming, this approach presumably saves the federal Medicaid program money, and we believe that this interpretation of the hospital-specific DSH cap is reasonable. To a large extent patient claims from prior years included in a given year should be offset by claims from the current year which could be included but were not due to uncertainty about that patient's status.

To prove this point, we went through the laborious exercise of subtracting from SFY 1997 and 1998 UCC the costs for uninsured indigent patients with prior dates of services, and adding into the UCC for those years the costs for patients with 1997 and 1998 dates of service whose indigent status was verified in later years. Our exercise showed that MCVH's original methodology provided an accurate estimate of the indigent care costs attributable to each year. In general, the costs attributable to prior years (but included in our calculations) were roughly equal to the costs attributable to future years (but omitted from our calculations). See Exhibit 4. For example, in 1998, the costs associated with indigent uninsured patients for prior years exceeded the costs for future years by approximately \$88,000. SFY 1997 was somewhat of an anomalous year, in that it was the first year of MCVH's new status as part of the MCV Hospitals Authority, instead of being part of VCU. As part of that new status, extra effort was made to close out prior year accounts. As a result, there were nearly \$10.7 million more in costs for uninsured indigents in prior years than there were for future years. Indeed, Exhibit 4 shows that recalculating SFYs 1995 and 1996 to include uninsured indigents for future years and

⁴¹ 42 U.S.C. § 1396r-4(g)(1)(A).

⁴² Letter from Sally K. Richardson, Director, Medicaid Bureau, to Donna Checkett, Chair, State Medicaid Director's Association, Jan. 10, 1995, at 2.

⁴³ *Id.*

exclude prior years would have resulted in increased costs in SFY 1995 and SFY 1996 of about \$10.5 million (which is roughly equivalent to the \$10.7 million in SFY 1997).

MCVH's methodology, accepted by DMAS, was a reasonable, conservative and acceptable approach to estimating the actual uncompensated costs of care.

C. MCVH did not offset payments received before including bad debt costs in UCC.

The OIG claims that MCVH did not offset payments received before including bad debts. We admit that MCVH did not offset payments received before including bad debts. We have since calculated these amounts and included them in the third column of Exhibits 2 and 3. According to our calculations, the future payment received from bad debt recorded was \$494,431 for 1997 and \$666,839 for 1998. Despite inclusion of these payments, comprehensively adopting the OIG's methodology (described below) resulted in greater costs than was previously accounted for using MCVH's prior methodology for calculating UCC.

D. Using OIG's methodology, MCVH's UCC is greater than the amount of DSH payments received, so no overpayments occurred and no adjustment is necessary to return funds to the federal government.

Although we believe that MCVH's methodology for determining the costs included in UCC for SFYs 1997 and 1998 was reasonable and permissible under the Medicaid statute, we are willing to recognize the reasonableness of the OIG's recommendations regarding the UCC calculation for the purposes of this document.⁴⁴ Therefore, MCVH has engaged in an extensive process of reexamining all of MCVH's claims data for SFYs 1997 and 1998 and recalculating our UCC based on the OIG's methodology. These recalculations are contained in the third column of Exhibits 2 and 3. In summary, our recalculations result in identifying even greater amounts of UCC than we found in our original calculations. Because of this result, no overpayments occurred and no funds should be returned.

The format of our recalculation of UCC for SFYs 1997 and 1998 is similar to our original format. The calculations in the first section of our worksheet in Exhibits 2 and 3, relating to Medicaid cost report items, is completely unchanged. The second section, relating to Medicaid non-cost report items, is changed slightly to conform to the OIG auditor's oral assessment of Medicaid costs (even though not addressed in the written Draft Report). This change reduces UCC related to Medicaid HMO by approximately \$800,000.

More significant changes occur with regard to patients without insurance. With regard to patients eligible for the state's indigent care category, we include only that subset of costs attributable to indigents without insurance. Our original calculations for 1997, using the statistical methods described above, estimated \$80.8 million in costs for serving uninsured indigents; our revised calculations, looking only at the uninsured claims, show

⁴⁴ We maintain that our methodology was permissible and do not in any way mean to imply that we agree with the OIG's reasoning with regard to costs associated with physicians, as described above.

\$90.5 million. Our original calculations for 1998 estimated \$71.6 million in costs for serving uninsured indigents; our revised calculations show \$80.5 million.⁴⁵

Two additional steps are added in the indigent care category in order to comply with the OIG recommendations. First, to comply with the recommendation that we take out costs associated with services in prior years, we deduct those costs and include costs associated with the current year but previously recorded in future years. This step results in a net decrease in costs in 1997 of \$10.7 million and in 1998 of \$88,335.

Finally, at the OIG auditor's oral suggestion (also not included in the written Draft Report), we modified our original methodology to the extent that it excluded unpaid copayments that are the patient's responsibility under the state indigent care program. Following Virginia guidelines, MCVH had previously deducted unpaid copayments from indigents after calculating indigent care costs. The OIG auditor noted that the full cost should be included in UCC, so we have added back previously deducted unpaid copayment amounts for uninsured indigent patients of \$3.9 million in 1997 and \$3.7 million in 1998. The result of all of these changes to our methodology is an overall increase in indigent care costs of nearly \$3 million in 1997 and \$13.5 million in 1998. In 1997 indigent care costs increased from \$80.8 million to \$83.8 million and in 1998 indigent care costs increased from \$71.6 million to \$84.1 million using the OIG's suggested approach.

With respect to the bad debt portion of our costs, instead of including only bad debt accounts and statistically adjusting for the number of uninsured, we include costs related to all non-indigent self-pay patients. This scope is significantly broader than our original calculation since the self-pay accounts have not yet been determined to be bad debts, but, as noted by the OIG auditor when on-site, consistent with the DSH statute. In order to properly account for those costs, however, any and all future payments or recoveries received must be deducted when received, along with any current year payments associated with prior years. To estimate payments in future years related to the included self-pay patients, we reduced costs by the amount of any self-pay payments received in that year from patients served in prior years. Such estimates are explicitly permitted by the January 1995 letter.⁴⁶ The purpose of this estimation is to avoid continual recalculations in future years. In addition, if any patient previously counted as self-pay is later found to have insurance, all of the costs related to that patient are offset against self-pay costs in the year that such insurance status is confirmed (*e.g.*, by receipt of any third party payments).

Using this methodology, we calculated unreimbursed self-pay costs for the non-indigent patient population of \$36.5 million in 1997 and \$25.5 million in 1998. (These amounts compare with the approximately \$10.5 million and \$11.5 million in uninsured bad debt costs previously included for 1997 and 1998, respectively.) In addition, the category of

⁴⁵ These costs increased because the indigent patient category previously included credits for patients later found to not be indigent. There were more credits than debits for indigent patients with insurance, and thus omitting the indigent insured patients actually increased costs.

⁴⁶ Letter from Sally K. Richardson, Director, Medicaid Bureau, to Donna Checkett, Chair, State Medicaid Director's Association, Jan. 10, 1995, at 2.

"other state agency costs" is reduced in both years by just under \$1 million since these costs are included in the new non-indigent self-pay costs category.

Overall, this new calculation results in total uncompensated care costs (DSH cap) of \$143.2 million in 1997 and \$128.8 million in 1998, as compared to the original figures of \$117.3 million and \$104.4 million, respectively. Because these amounts are substantially higher than the prior estimates audited by the OIG, no adjustment is necessary. (Indeed, it should be noted that these revised amounts exceed the original figures by an amount greater than the other amounts the OIG contends are in question.)

This revised approach addresses all of the concerns about our previous methodology expressed by the OIG in the Draft Report. First, we no longer rely on statistical methods to estimate costs for uninsured patients in the indigent or bad debt pools. We include only the costs associated with indigent uninsured patients and non-indigent self-pay patients, all of whom are by definition without insurance. Any erroneous inclusion of insured patients for whom we later receive third party payments will be offset immediately as such payments are received. We would invite the OIG auditor to sample any of the accounts included among these costs. In contrast to MCVH's previous methodology, we would not expect to find any insured patients in the pool.

Second, under this revised methodology, no costs are included for services provided in prior years; we only include costs incurred in the current year. (As described above, we do estimate the payments we expect ultimately to receive for self-pay patients by offsetting payments received in the current year.) Again, we would invite the OIG auditor to sample these accounts to determine whether costs for prior years' services are included; we fully expect that there are none.

Finally, this methodology ensures that all payments received on accounts whose costs are included in our calculations will be offset against total UCC.

III. Other matters

In addition to the issues addressed above, the OIG raised two additional matters in the Draft Report. First, the OIG noted in its draft report that CMS had disallowed FFP for DSH claims made by DMAS that allegedly did not meet a Federal time limit. Second, the OIG questioned MCVH's inclusion in its UCC calculation of the cost of providing hospital services to prisoners of the Virginia Department of Corrections. The OIG acknowledged that CMS had "not issued statewide guidance on this issue." Draft Report at 10. We believe that both of these items should be removed from the OIG's final report for reasons discussed below.

This portion of VCU's response has been deleted as it pertained to matters included in the draft report which are no longer contained in the final report.

This portion of VCU's response has been deleted as it pertained to matters included in the draft report which are no longer contained in the final report.

B. The OIG should not include comments regarding prisoner medical costs since these issues have been dealt with prospectively by CMS.

The OIG's last section discusses MCVH's inclusion of the costs of providing hospital services to prisoners of the Virginia Department of Corrections. Although the OIG does not make any recommendations regarding the costs claimed by MCVH in SFYs 1997 and 1998, the OIG states its belief that "CMS never intended to approve SPAs that allowed payments" for prisoners and includes the section "to alert CMS to the extent of Virginia's use of the Medicaid DSH program to pay for the costs of medical care to inmates." Draft Report at 11.

We disagree with the OIG's conclusion regarding whether it is permissible to include in UCC the costs of providing hospital services to prisoners. However, we also recognize that since the writing of the Draft Report CMS has published guidance on this precise issue. On August 16, 2002, CMS published a letter to State Medicaid Directors that clarifies that the costs of providing health care to prisoners may not be included as UCC for DSH purposes.⁴⁸ Although we disagree with both the OIG and CMS's reasoning on this issue, this report is not the correct forum for a discussion of these issues. Furthermore, since CMS has finally issued guidance on this issue and made clear in a letter to another state that it has no intention of applying this new interpretation retroactively,⁴⁹ there is no remaining purpose in including this section in a report on DSH payments in SFYs 1997 and 1998.

⁴⁸ Letter from Dennis Smith to State Medicaid Directors (Aug. 16, 2002) at 1-2.

⁴⁹ Letter from Andrew Fredrickson, Chief, Medicaid Operations and Financial Management Branch, Division of Medicaid and State Operations, Centers for Medicare & Medicaid Services Region VI to Ben Bearden, Director, Bureau of Health Services Financing, Louisiana Department of Health and Hospitals Mar. 15, 2002 (noting "that CMS will disallow the FFP for any portion of DSH payments made for services on or after July 1, 2002, for services provided to prisoners").

Exhibit 1

EXHIBIT C - Care for Indigent Patients

**Fiscal Year 1998
Clinical, Educational and Research Services Reconciliation Agreement**

**Services Provided By
Virginia Commonwealth University (University)**

To

**The Virginia Commonwealth University Health System Authority (formerly known as the
Medical College of Virginia Hospitals Authority (Authority))**

- I. Type of Service:** Professional medical and dental services to indigent patients for necessary clinical services provided without restriction to race, sex, national origin, age, residence or financial status. Funding provided through this mechanism is the funding of last resort for these patients.
- II. Service Locations:** MCV Hospitals and Clinics, including MCV Campus and satellite locations
- III. Description of Services and Need Justification:** The Authority mission includes the provision of necessary medical and dental services to indigent patients. This mission can not be fulfilled without professional services provided by qualified physicians, dentists and other licensed healthcare providers.
- IV. Funding Calculation Methodology:** MCV Hospitals historically has received funding from the Virginia Department of Medical Assistance Services (DMAS) for the care and treatment of indigent patients in an amount that is less than the combined actual cost of hospital and professional services to such patients (the "Combined Actual Indigent Care Costs"). The Authority shall pay the University for professional services to indigent patients based on the following formula:

$$\begin{array}{rcccl} \text{Indigent Care} & & & & \\ \text{Reimbursement} & & & & \\ \text{from DMAS} & \times & \text{University} & = & \text{Payment to} \\ \hline \text{Hospital + University Actual Cost} & & \text{Actual Cost} & & \text{University For} \\ \text{To Provide Care to Indigent Patients} & & & & \text{Indigent Care} \\ & & & & \text{Services} \end{array}$$

provided, however, that in no event shall the payment to the University for indigent care exceed the University's actual cost of providing such care.

For purposes of this Exhibit C, the "University's Actual Cost" was to be the actual costs incurred by the University in providing such services, or, if such services are provided pursuant to subcontract, the actual costs incurred by the subcontractor providing such services. Indigent Care Services were provided by the University through a subcontract

between the University and MCV Physicians, so MCV Physicians' costs were used in this calculation.

- V. **Funding Reconciliation:** Based upon internal review and completion of the annual financial audits of the University and the Authority, the parties have determined that the University was not otherwise reimbursed for its provision of indigent care services in the fiscal year ending June 30, 1998, and that the amount payable by the Authority to the University for indigent care services in such period is \$11,089,629, calculated as follows:

Indigent Care Reimbursement from DMAS:	\$70,300,000
Hospital Actual Cost to Provide Indigent Care:	\$82,752,299
University Actual Cost to Provide Indigent Care:	\$15,498,844

$$\frac{\$70,300,000}{\$82,752,299 + \$15,498,844} = 0.7155$$

$$0.7155 \times \$15,498,844 = \$11,089,629$$

The indigent care costs set forth above include unreimbursed Medicaid costs as a result of the cost reporting conventions applicable to the Authority. Reimbursement to the University, however, is limited to the actual indigent care costs incurred, excluding unreimbursed Medicaid costs. Such costs were \$12,718,043 in Fiscal Year 1999. Data in support of this final reconciliation is maintained in the office of the Chief Financial Officer of the Authority and the office of the Associate Dean for Administration, University School of Medicine. It was further determined that the interim payments received by the University for indigent care services totaled \$14,092,798. Such interim payments exceeded the \$11,089,629 due by \$3,003,169.

VI. **Market Value Comparison of Services Provided:**

-Estimated -Professional Service Charges	-\$38.0M
-Professional Service Cost	-\$15.5M
-Authority Reimbursement	-\$11,089,629

- IX. **Authority Contacts:** Dr. Hermes A. Kontos, Chief Executive Officer
Mr. Carl R. Fischer, Executive Vice President of Corporate Functions
Mr. Dominic J. Puleo, Chief Financial Officer

- X. **University Contacts:** Dr. Hermes A. Kontos, VCU Vice President of Health Sciences
Mr. William M. Gleason, VCU Associate Dean for

Exhibit 2

Medical College of Virginia Hospitals Authority at VCU Uninsured Costs For the Federal DSH Limits For Fiscal Year 6/30/97

MEDICAID COST REPORT ITEMS

	Updated 7/10/00 6/30/97	Updated 5/31/01 6/30/97	Updated 11/1/02 6/30/97
	Original External Audit	OIG On-Site Comments	OIG Draft Report
Total Medicaid Costs Per Cost Report	\$ 48,170,523	\$ 48,170,523	\$ 48,170,523
Total Medicaid Cost Report Reimbursements	\$ 51,071,206	\$ 51,071,206	\$ 51,071,206
Less: Prior Year GME	\$ -	\$ -	\$ -
Less: Prior Year DSH	\$ (1,195,253)	\$ (1,195,253)	\$ (1,195,253)
Net Current Year Medicaid Cost Report Payments	\$ 49,875,953	\$ 49,875,953	\$ 49,875,953
Excess Costs over Net payments or (Payments Over Costs)	\$ (1,705,430)	\$ (1,705,430)	\$ (1,705,430)

MEDICAID NON COST REPORT ITEMS

Medicaid Days over 21 are being captured through Indigent Care

Medicaid Unreimbursed Lab Costs (Fee Schedule)	\$ 27,291	\$ 192,748	\$ 192,748
Medicaid Unreimbursed ER Costs (Fee Schedule)	\$ -	\$ -	\$ -
Medicaid Unreimbursed Peds TX Costs (Not in Cost Report)	\$ 17,277	\$ 17,277	\$ 17,277
Medicaid HMO Inpatient Shortfall (Not in Cost Report)	\$ 5,628,625	\$ 5,570,512	\$ 5,191,456
Medicaid HMO Outpatient Shortfall (Not in Cost Report)	\$ 1,793,259	\$ 1,722,740	\$ 1,788,300
Total Unreimbursed Costs not Captured on the Cost Report	\$ 7,466,452	\$ 7,503,277	\$ 7,189,781

INDIGENT CARE COSTS (from I/C Cost Reports)

Note: There is not a breakout of instate vs out-of-state indigent care writeoffs because we only adjust instate accounts.

I/P Indigent Care Cost (net of copays) per the Cost Report	\$ 61,563,633	\$ 61,563,633	\$ 62,090,506
% of Costs Related to Uninsured Individuals	89.63%	96.59%	100.00%
Uninsured I/P Indigent Costs	\$ 55,179,484	\$ 59,465,237	\$ 62,090,506
O/P Indigent Care Cost (net of copays) per the Cost Report	\$ 28,148,963	\$ 28,148,963	\$ 28,434,715
% of Costs Related to Uninsured Individuals	91.03%	96.38%	100.00%
Uninsured O/P Indigent Costs	\$ 25,623,348	\$ 27,128,803	\$ 28,434,715
Subtotal Uninsured Indigent Costs (I/P and O/P)	\$ 80,802,832	\$ 86,594,040	\$ 90,525,221

OIG RECOMMENDED ADJUSTMENTS

Prior Years Activity Out (Charges reduced to Costs)			\$	(23,758,995)
Future Years Activity In (Charges reduced to Costs)			\$	13,075,533
Omitted Inpatient Copays			\$	2,683,546
Omitted Outpatient Copays			\$	1,227,189
Adjusted Uninsured Indigent Costs	80,802,832	86,594,040		83,752,494

Exhibit 2

BAD DEBT COSTS

Bad Debt Write-offs (From our Financial Statements)	\$	21,015,804	\$	21,015,804	N/A
% Related to Uninsured Individuals (Used MCV's %'s)		81.74%		88.97%	N/A
Ratio of Costs to Charges per Medicare Cost Report		61.17%		61.17%	N/A
Bad Debt Costs of Uninsured Individuals	\$	10,507,657	\$	11,436,978	N/A

NON-INDIGENT SELF-PAY (OIG RECOMMENDED)

Non-Indigent Self-Pay Costs			\$	84,981,367
less: Any Self Pay Payments Received on those Costs			\$	(494,431)
less: Prior Year Self Pay Payments and Backouts (Recoveries)			\$	(47,946,112)
Adjusted Non-indigent Self-Pay Costs			\$	36,540,824

OTHER STATE AGENCY COSTS

Not included in Bad Debt or Indigent Care writeoffs
Ratio of Costs to Charges per Medicare Cost Report Used

Corrections Inpatient Costs (100% costs)	\$	5,364,166	\$	5,364,166	\$	5,364,166
Corrections Outpatient Costs (100% costs)	\$	1,611,034	\$	1,611,034	\$	1,611,034
SLH Inpatient Costs (100% costs)	\$	602,117	\$	602,117	\$	-
SLH Outpatient Costs (100% costs)	\$	295,882	\$	295,882	\$	-
Total State Agency Costs	\$	7,873,199	\$	7,873,199	\$	6,975,200
TOTAL NON-PHYSICIAN UNINSURED COSTS	\$	99,183,689	\$	105,904,218	\$	127,268,518
PHYSICIAN COSTS (ACTUAL)	\$	12,331,351	\$	10,436,541	\$	10,436,541
TOTAL UNREIMBURSED UNINSURED COSTS	\$	111,515,040	\$	116,340,759	\$	137,705,059
MEDICAID COST REPORT ITEMS (UNREIMBURSED)	\$	(1,705,430)	\$	(1,705,430)	\$	(1,705,430)
MEDICAID NON-COST REPORT ITEMS (UNREIMBURSED)	\$	7,466,452	\$	7,503,277	\$	7,189,781
TOTAL UNREIMBURSED MEDICAID COSTS	\$	5,761,022	\$	5,797,847	\$	5,484,351
TOTAL MCVH FEDERAL DSH CAP	\$	117,276,061	\$	122,138,606	\$	143,189,410

Exhibit 3

Medical College of Virginia Hospitals Authority at VCU Uninsured Costs For the Federal DSH Limits For Fiscal Year 6/30/98

MEDICAID COST REPORT ITEMS

	Updated 2/12/01 6/30/98	Updated 5/31/01 6/30/98	Updated 11/1/02 6/30/98
	Original External Audit	OIG On-Site Comments	OIG Draft Report
Total Medicaid Costs Per Cost Report	\$ 52,301,518	\$ 52,301,518	\$ 52,301,518
Total Medicaid Cost Report Reimbursements	\$ 59,490,412	\$ 59,490,412	\$ 59,490,412
Less: Prior Year GME	\$ -	\$ -	\$ -
Less: Prior Year DSH	\$ (113,708)	\$ (113,708)	\$ (113,708)
Net Current Year Medicaid Cost Report Payments	\$ 59,376,704	\$ 59,376,704	\$ 59,376,704
Excess Costs over Net payments or (Payments Over Costs)	\$ (7,075,186)	\$ (7,075,186)	\$ (7,075,186)

MEDICAID NON COST REPORT ITEMS

Medicaid Days over 21 are being captured through Indigent Care

Medicaid Unreimbursed Lab Costs (Fee Schedule)	\$ 142,877	\$ 142,877	\$ 142,877
Medicaid Unreimbursed ER Costs (Fee Schedule)	\$ -	\$ -	\$ -
Medicaid Unreimbursed Peds TX Costs (Not in Cost Report)	\$ (65,161)	\$ (65,161)	\$ (65,161)
Medicaid HMO Inpatient Shortfall (Not in Cost Report)	\$ 5,305,980	\$ 4,019,016	\$ 4,105,365
Medicaid HMO Outpatient Shortfall (Not in Cost Report)	\$ 1,471,526	\$ 1,383,313	\$ 2,000,343
Total Unreimbursed Costs not Captured on the Cost Report	\$ 6,855,222	\$ 5,480,044	\$ 6,183,424

INDIGENT CARE COSTS (from I/C Cost Reports)

Note: There is not a breakout of instate vs out-of-state indigent care writeoffs because we only adjust instate accounts.

I/P Indigent Care Cost (net of copays) per the Cost Report	\$ 54,312,318	\$ 54,312,318	\$ 54,797,893
% of Costs Related to Uninsured Individuals (Used MCV %'s)	89.63%	97.81%	100.00%
Uninsured I/P Indigent Costs	48,680,131	53,125,223	54,797,893
O/P Indigent Care Cost (net of copays) per the Cost Report	\$ 25,189,166	\$ 25,189,166	\$ 25,669,390
% of Costs Related to Uninsured Individuals (Used MCV %'s)	91.03%	97.25%	100.00%
Uninsured O/P Indigent Costs	22,929,113	24,497,478	25,669,390
Subtotal Uninsured Indigent Costs (I/P and O/P)	71,609,244	77,622,701	80,467,283

OIG RECOMMENDED ADJUSTMENTS

Prior Years Activity Out (Charges reduced to Costs)			\$	(22,809,819)
Future Years Activity In (Charges reduced to Costs)			\$	22,721,484
Omitted Inpatient Copays			\$	2,556,368
Omitted Outpatient Copays			\$	1,185,389
Adjusted Uninsured Indigent Costs	71,609,244	77,622,701		84,120,705

Exhibit 3

BAD DEBT COSTS

Bad Debt Write-offs (From our Financial Statements)	\$	22,836,637	\$	22,836,637	N/A
% Related to Uninsured Individuals (Used MCV's %'s)		81.74%		84.67%	N/A
Ratio of Costs to Charges per Medicare Cost Report		61.72%		59.61%	N/A
Bad Debt Costs of Uninsured Individuals	\$	11,520,716	\$	11,525,602	N/A

NON-INDIGENT SELF-PAY (OIG RECOMMENDED)

Non-Indigent Self-Pay Costs			\$	87,866,252
less: Any Self Pay Payments Received on those Costs			\$	(666,839)
less: Prior Year Self Pay Payments and Backouts (Recoveries)			\$	(61,710,814)
Adjusted Non-Indigent Self-Pay Costs			\$	25,488,599

OTHER STATE AGENCY COSTS

Not included in Bad Debt or Indigent Care writeoffs

Ratio of Costs to Charges per Medicare Cost Report Used

Corrections Inpatient Costs (100% costs)	\$	5,942,951	\$	5,739,781	\$	5,739,781
Corrections Outpatient Costs (100% costs)	\$	1,685,732	\$	1,628,103	\$	1,628,103
SLH Inpatient Costs (100% costs)	\$	853,723	\$	824,537	\$	-
SLH Outpatient Costs (100% costs)	\$	214,348	\$	207,020	\$	-
Total State Agency Costs	\$	8,696,755	\$	8,399,442	\$	7,367,884
TOTAL NON-PHYSICIAN UNINSURED COSTS	\$	91,826,715	\$	97,547,745	\$	116,977,188
PHYSICIAN COSTS (ACTUAL)	\$	12,792,798	\$	12,718,043	\$	12,718,043
TOTAL UNREIMBURSED UNINSURED COSTS	\$	104,619,513	\$	110,265,788	\$	129,695,231
MEDICAID COST REPORT ITEMS (UNREIMBURSED)	\$	(7,075,186)	\$	(7,075,186)	\$	(7,075,186)
MEDICAID NON-COST REPORT ITEMS (UNREIMBURSED)	\$	6,855,222	\$	5,480,044	\$	6,183,424
TOTAL UNREIMBURSED MEDICAID COSTS	\$	(219,964)	\$	(1,595,142)	\$	(891,762)
TOTAL MCVH FEDERAL DSH CAP	\$	104,399,549	\$	108,670,646	\$	128,803,470

Exhibit 4

VCUHS Uninsured Indigent Care Writeoffs Reallocation to Fiscal Year of Discharge for Multiple Provider Fiscal Years

Description	6/30/95 only Uninsured	6/30/96 only Uninsured	6/30/97 only Uninsured	6/30/98 only Uninsured
Prior Year Activity Breakdown				
1997	\$ -	\$ -	\$ -	\$ 12,725,842
1996	\$ -	\$ -	\$ 20,619,743	\$ 13,778,773
1995	\$ -	\$ 20,812,298	\$ 4,262,362	\$ 1,361,510
Prior to 1995	\$ 21,478,471	\$ 7,171,590	\$ 5,917,733	\$ 3,192,997
Activity from Other Years Out - Total	\$ 21,478,471	\$ 27,983,888	\$ 30,799,838	\$ 31,059,122
Charges Reduced To Costs - Out	\$ 15,722,241	\$ 19,770,617	\$ 23,758,995	\$ 22,809,819
Activity from Other Years In - 2002	\$ 101,777	\$ 89,422	\$ 394,068	\$ 466,737
Activity from Other Years In - 2001	\$ 272,685	\$ 282,435	\$ 60,537	\$ 8,405,543
Activity from Other Years In - 2000	\$ 310,128	\$ 245,880	\$ 792,780	\$ 14,258,613
Activity from Other Years In - 1999	\$ 666,118	\$ 1,267,825	\$ 2,977,167	\$ 7,807,947
Activity from Other Years In - 1998	\$ 1,361,510	\$ 13,778,773	\$ 12,725,842	n/a
Activity from Other Years In - 1997	\$ 4,262,362	\$ 20,619,743	n/a	n/a
Activity from Other Years In - 1996	\$ 20,812,298	n/a	n/a	n/a
Activity from Other Years In - 1995	n/a	n/a	n/a	n/a
Activity from Other Years In - Total	\$ 27,786,877	\$ 36,284,079	\$ 16,950,393	\$ 30,938,840
Charges Reduced To Costs - In	\$ 20,339,994	\$ 25,634,702	\$ 13,075,533	\$ 22,721,484
Overages & Underages (Costs)	\$ 4,617,753	\$ 5,864,085	\$ (10,683,461)	\$ (88,335)